

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 11001		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11001	
1. NAME OF DECEASED (Type or Print) <i>Helen Cunningham</i>			2. DATE AND HOUR OF DEATH <i>11-19-71</i> <i>2:45 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Mem. Nursing Home</i> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1802</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>27 N. Carey St.</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1896</i>	9. AGE (in years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
10B. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>219-54-3252</i>		17. INFORMANT ADDRESS
18. <i>4-10-71</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pos. Coronary</i> (B) <i>Generalized arterio-sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Chronic Brain Syndrome</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-29-1971</i> to <i>11-19-1971</i> that (I) (we) last saw the deceased alive on <i>11-18-1971</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. I. Baykaler, M.D.</i> DEGREE			23B. DATE SIGNED <i>11-19-71</i>		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <i>A. I. BAYKALER, M.D.</i> DEGREE			23D. ADDRESS <i>301 Mc Mechen St. Balto. Md.</i>		
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <i>11/22/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHO</i>	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 30 1971</i>	
25B. NAME OF REGISTRAR <i>Robert E. Tabor, R.D.</i>		25C. FUNERAL DIRECTOR		25D. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

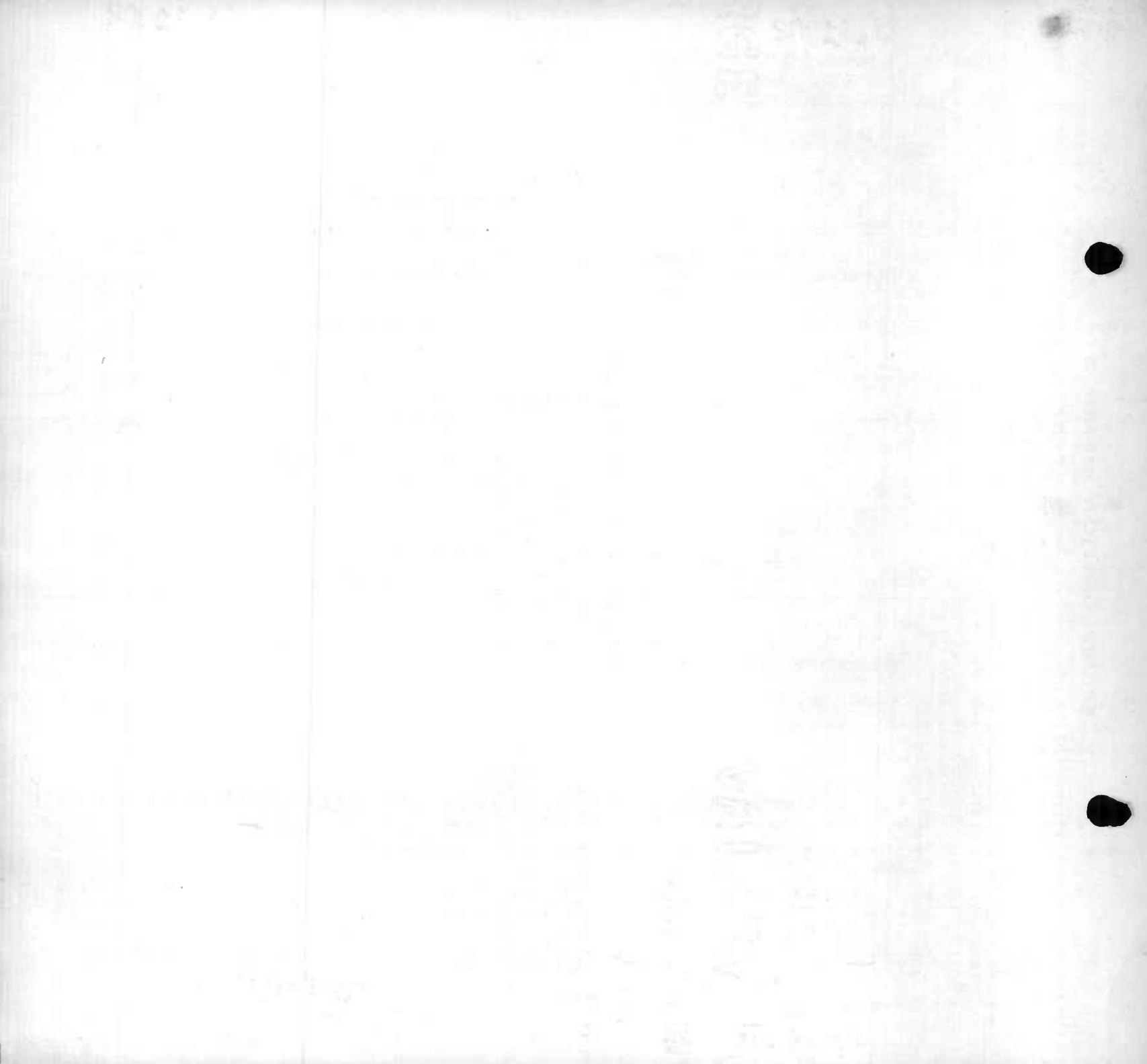
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **71 11002**

BIRTH NO. 71 11002		1. NAME OF DECEASED (Type or Print) BABY BOY JOHNSON (MOTHER) (MARY)		2. DATE AND HOUR OF DEATH 10/20/71 10:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY 3107 Virginia Ave. 2716 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Maryland 21215	
5. SEX MALE	6. RACE NEGROE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/20/71	9. AGE (In years lost birthday)	10. Under 1 Yr. Months: Days: Hours: Min. 20 min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Edward C. Johnson			14. MOTHER'S MAIDEN NAME Mary Green		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. 77691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH INTRACRANIAL HAEMORRHAGE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY (B) DUE TO, OR AS A CONSEQUENCE OF: PRIMARY APNOEA (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10/20/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/20/71 (10:55 PM) to 10/20/71 (11:15 PM) and that (I) (we) lost saw the deceased alive on 10/20/71 (11:15 PM) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Arun K. Pramanik				23B. DATE SIGNED 10/20/71	
23C. PHYSICIAN'S NAME (Type) ARUN K. PRAMANIK M.D.				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) 11-22-71		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farley R.D.		25C. NAME OF FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				REG. NO. 71 11003	
<div> <div>71 11003</div> <div>11-21040</div> </div>					
1. NAME OF DECEASED (Type or Print) <i>Boby Bay Miller</i>			2. DATE AND HOUR OF DEATH <i>11/9/71</i> <i>4:30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2717</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI HOSP OF BALTO.</i> <i>BELVEDERE + GREENSPRING</i>			C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>M</i>			6. RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			B. DATE OF BIRTH <i>11/9/41</i>		9. AGE (In years last birthday) <i>30</i>
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>SINAI HOSP. BALTO, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A</i>
13. FATHER'S NAME <i>C. Leamas Jackson</i>			14. MOTHER'S MAIDEN NAME <i>Beonette Jackson</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <i>776.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Primary Apnea</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/9/71</i> to <i>11/9/71</i> , that (I) (we) last saw the deceased alive on <i>30 M 11/9/71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nozam Radfar, M.D.</i>				23B. DATE SIGNED <i>11/9/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>NEZAM RADFAR, M.D.</i>				23D. ADDRESS <i>SINAI HOSPITAL, BALTO, MD, 21215</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>11-22-71</i>		24C. NAME OF CEMETERY <i>ANTHONY BOARD OF MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Jackson, M.D.</i>		25C. FUNERAL DIRECTOR <i>UNIVERSITY MEDICAL SCHOOL</i>	
				25D. ADDRESS <i>MORTUARY SERVICE - BCHD</i>	

Ref. Bot. Miller

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71-11004</u>
BIRTH NO. <u>71-11004</u>		1. NAME OF DECEASED (Type or Print) <u>BANKS, BABY GIRL</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>Nov. 19, 1971</u> <u>10³⁰</u> A.M.		
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME AND HOSPITAL</u> <u>100 No</u> <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>843</u>		
5. SEX <u>F</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>Nov. 5, 1971</u>		9. AGE (In years last birthday) <u>14</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>RICHARDS BANKS</u>		14. MOTHER'S MAIDEN NAME <u>YVONNE EATON</u> <u>1413 N. Potomac St.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <u>746.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CARDIO-RESPIRATORY ARREST</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CONGENITAL HEART DISEASE - PREMATURE</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> 19 <u>71</u> to <u>11/19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/19</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Humberto G. Hernandez MD</u>		23B. DATE SIGNED <u>11/19/71</u>		23C. PHYSICIAN'S NAME (Type) <u>HUMBERTO G. HERNANDEZ MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11-22-71</u>		24C. LOCATION <u>CHURCH HOME AND HOSPITAL</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jaber, M.D.</u>		25C. FUNERAL SERVICE <u>MORTUARY SERVICE - BCHD</u>



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11005
BIRTH NO. 71 11005		1. NAME OF DECEASED (Type or Print) SEIBEL, GORDON L		
2. DATE AND HOUR OF DEATH NOVEMBER 22, 1971 9:30A M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
C. CITY OR TOWN LANS DOWNE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		
E. STREET AND NUMBER 934 CATAWBA CT 21227		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER 10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT		
8. DATE OF BIRTH 01/10/15 9. AGE (In years lost birthday) 56		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME WILLIAM SEIBEL		14. MOTHER'S MAIDEN NAME ANNETTA GODWIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-1315		17. INFORMANT Mrs. Alice R. Seibel, 934 Catawba Court 21227
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (B) Congestive heart failure grade III 2-3 weeks (C) Arteriosclerotic Cardio-Vascular Dis. Several years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 19 71 to NOVEMBER 22 19 71 that (I) (we) last saw the deceased alive on NOVEMBER 22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Lewis P. Gundry M.D.		23B. DATE SIGNED 11/22/71		23C. PHYSICIAN'S NAME (Type) LEWIS P. GUNDRY M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-26-1971		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farley R.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24E. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVES		

Y 526

71 11006

BALTIMORE CITY HEALTH DEPARTMENT

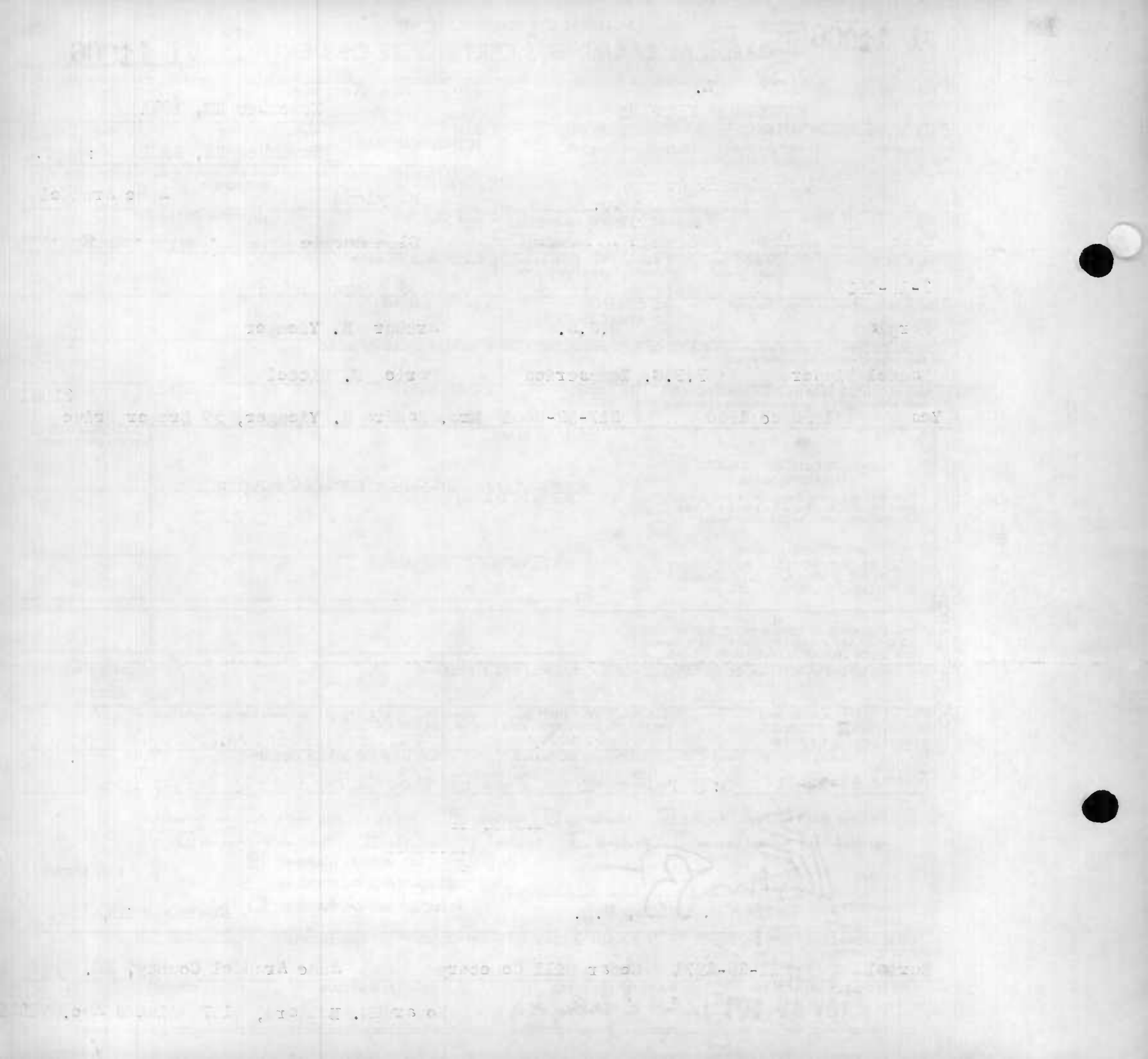
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 11006

BIRTH NO.

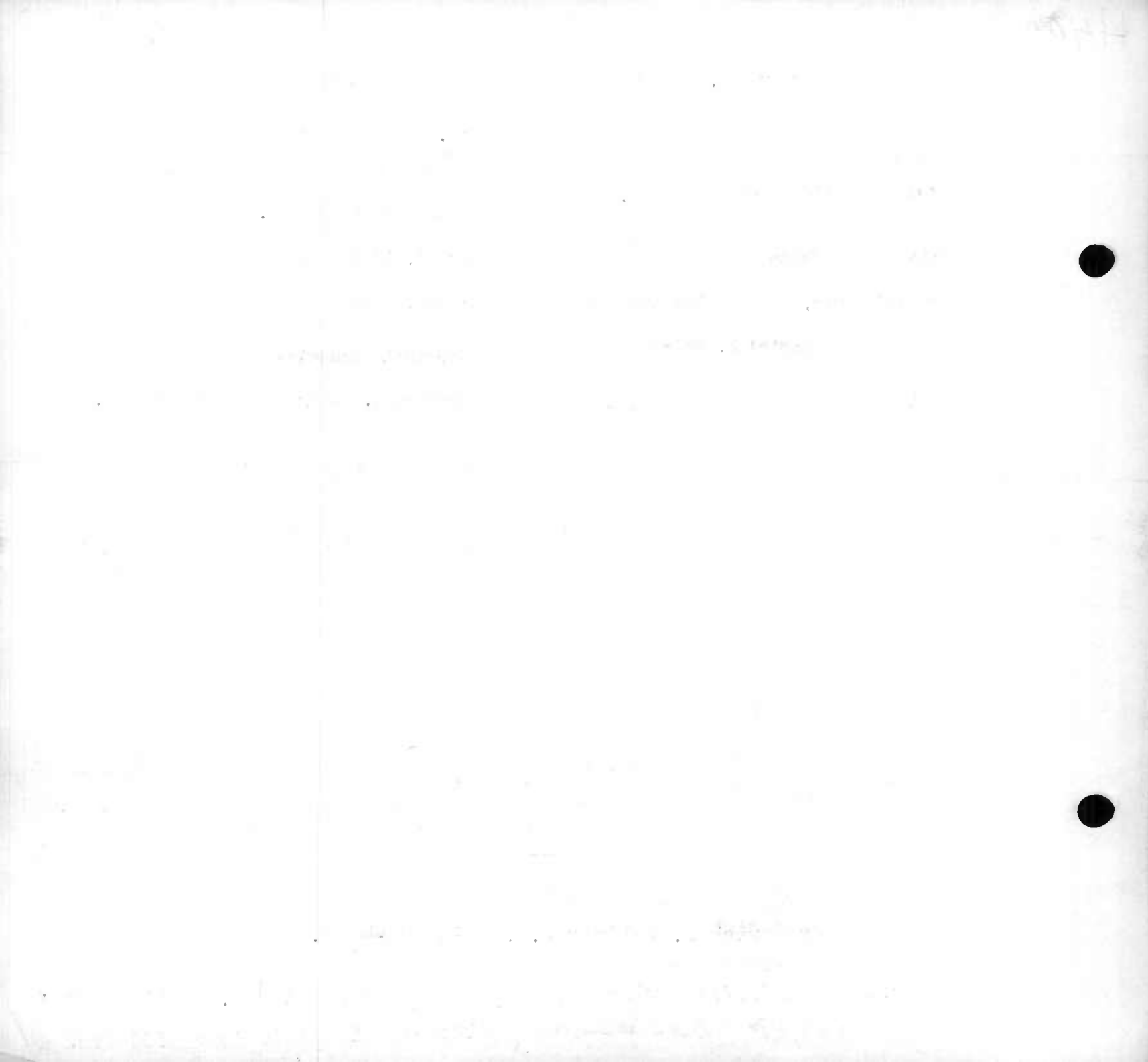
1. NAME OF DECEASED (Type or Print) EDWARD YIENGER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 22, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3221 Frederick Avenue Pittsburg Paint & Glass Co.)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 22, 1971 4:24 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Glen Burnie
9. DATE OF BIRTH 2-19-1936		10. AGE (In years lost birthday) 35	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.	E. STREET AND NUMBER 59 Bremer Drive
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handel Dipper		14B. KIND OF BUSINESS OR INDUSTRY P.P.G. Industries	13. FATHER'S NAME Arthur B. Yienger
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1958 to 1960		17. SOCIAL SECURITY NO. 217-32-9441	15. MOTHER'S MAIDEN NAME Marie F. Hittel
18. INFORMANT Mrs. Sandra K. Yienger		ADDRESS 21061 59 Bremer Drive	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Multiple gunshot wounds DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____			
20A. DATE OF OPERATION 11-22-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 2000	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Factory	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3221 Frederick Ave. = Pittsburg Paint & Glass Co.		22F. HOW DID INJURY OCCUR? Shot during work by sniper fire	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 11-22-71 3:19 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-26-1971	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel County, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H400

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11007</u>	
BIRTH NO. <u>71 11007</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Edward D. Haley			2. DATE AND HOUR OF DEATH 11/24/1971 <u>8:45 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1515 Burnwood Rd.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1515 Burnwood Rd.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1885		9. AGE (In years last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pres.			10B. KIND OF BUSINESS OR INDUSTRY Building Supply		11. BIRTHPLACE (State or foreign country) Dedham, Mass
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Daniel E. Haley		
14. MOTHER'S MAIDEN NAME Margaret Connaire			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW I		
16. SOCIAL SECURITY NO. 212 05 9811			17. INFORMANT Margaret H. Haley ADDRESS 1515 Burnwood Rd.		
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral arteriosclerosis</u> <u>2 years</u></p> <p>(B) <u>Generalized arteriosclerosis</u> <u>6 yrs</u></p> <p>(C) _____</p> </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 27 19 71</u> to <u>Nov 24 19 71</u>		and that (I) (we) lost saw the deceased alive on <u>Oct 27 19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Frederick J. Vollmer M.D.</u>				23B. DATE SIGNED <u>11-25-71</u>	
23C. PHYSICIAN'S NAME (Type) Frederick J. Vollmer M.D.				23D. ADDRESS 6100 York Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/71		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
24D. LOCATION (City, town, or county) (State) Padonia Rd. Balto Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home ADDRESS 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K 500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11008

BIRTH NO. 71 11008

1. NAME OF DECEASED
(Type or Print)

KENNY, John T.

2. DATE AND HOUR OF DEATH

11/22/71 400 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
Maryland

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

4300 N. Charles Street, Apt. 5E

5. SEX

Male

6. RACE

Cauc.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9/15/08

9. AGE (In years last birthday)

63

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Senior V.P. Merc. Safe Banking

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Kenny

14. MOTHER'S MAIDEN NAME

Catherine Doherty

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

yes

WW II

16. SOCIAL SECURITY NO.

214-03-5892

17. INFORMANT

ADDRESS

Mrs. K. Doris Kenny 4300 N. Charles St.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Tension Pneumothorax

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

115 minutes

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Emphysema - Chronic bronchitis

10 years

(C)

Chronic obstructive pulmonary disease

10 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Congestive heart failure

2 months

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 21 1971 to November 22 1971 that (I) (we) last saw the deceased alive on November 22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Eloise M. Harman

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/22/71

23C. PHYSICIAN'S NAME (Type)

Eloise Harman,

M.D.

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

burial

24B. DATE

11/24/71

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Baltimore,

Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

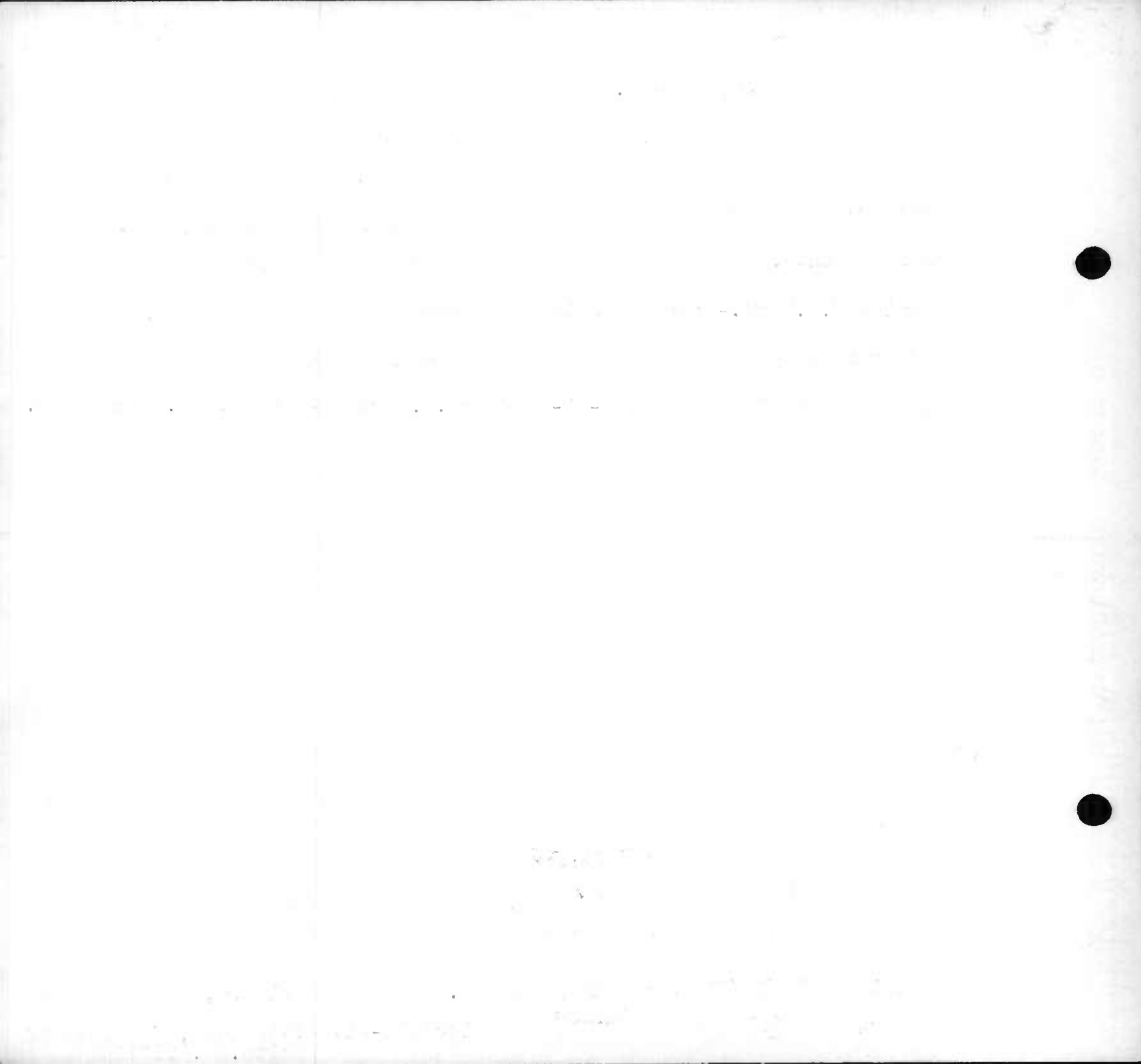
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Mitchell-Wiedefeld Home, 6500 York Rd

ADDRESS

Balto. Md. 21212



FUNERAL DIRECTOR: IMPORTANT

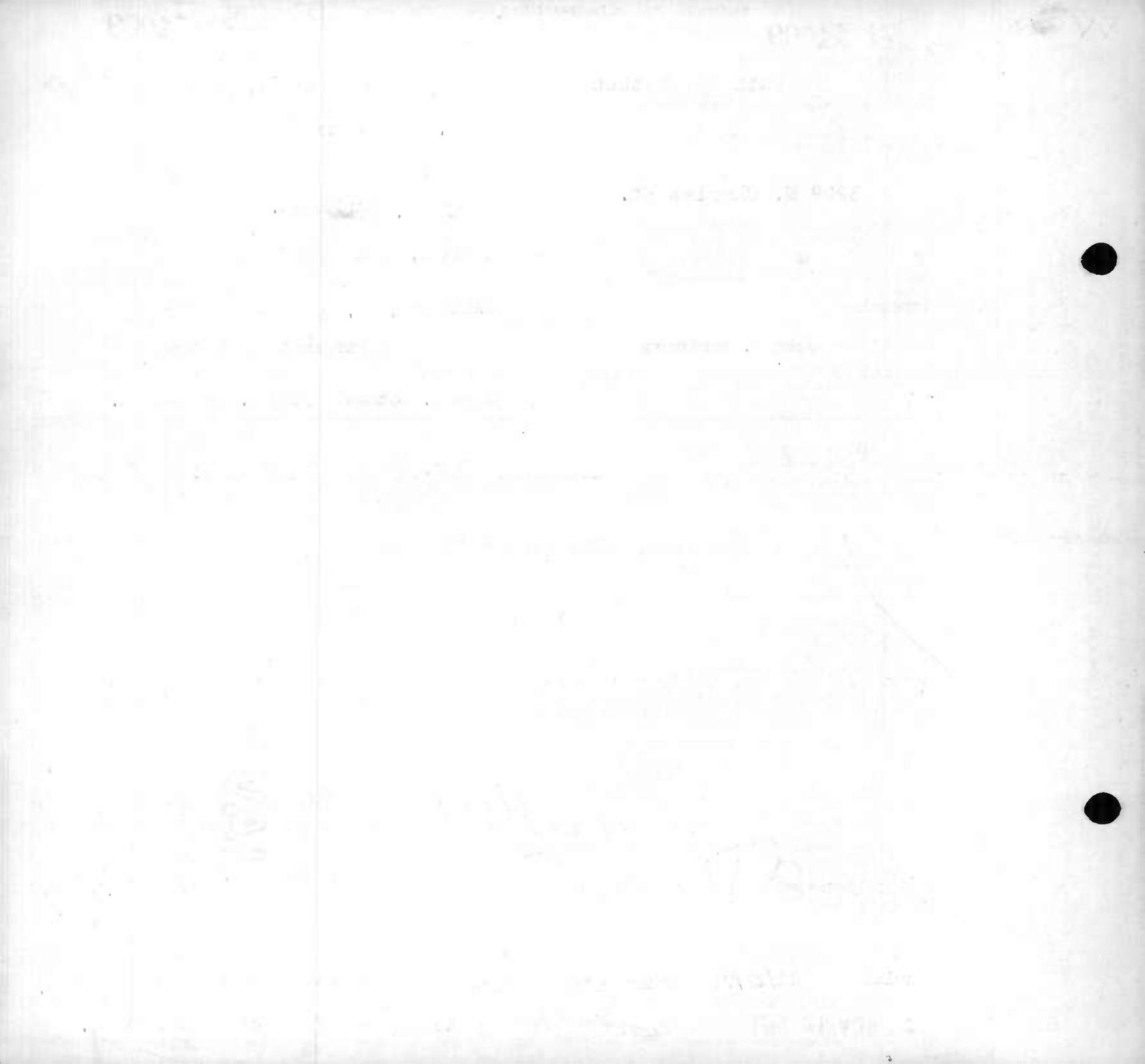
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. **71 11009**

BIRTH NO. **71 11009**

1. NAME OF DECEASED (Type or Print) Ruth R Wathen			2. DATE AND HOUR OF DEATH November 23, 1971 10:20 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3209 N. Charles St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto 1202		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3209 N. Charles St.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1902		9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John O. Robinson		
14. MOTHER'S MAIDEN NAME Margaret E unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS John D. Wathen 3209 N. Charles St.		
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>Antecedent Causes</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of rectum with metastases</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="width: 5%; text-align: center;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>1 yr.</p> </div> </div>					
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION Dec. 1970		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Rectum		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/19 19 70 to 11/23 19 71 , that (I) (we) last saw the deceased alive on 11/21/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William D. Penner				23B. DATE SIGNED 11/24/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/71		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Reistertown Rd Pikesville Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971			
25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.			



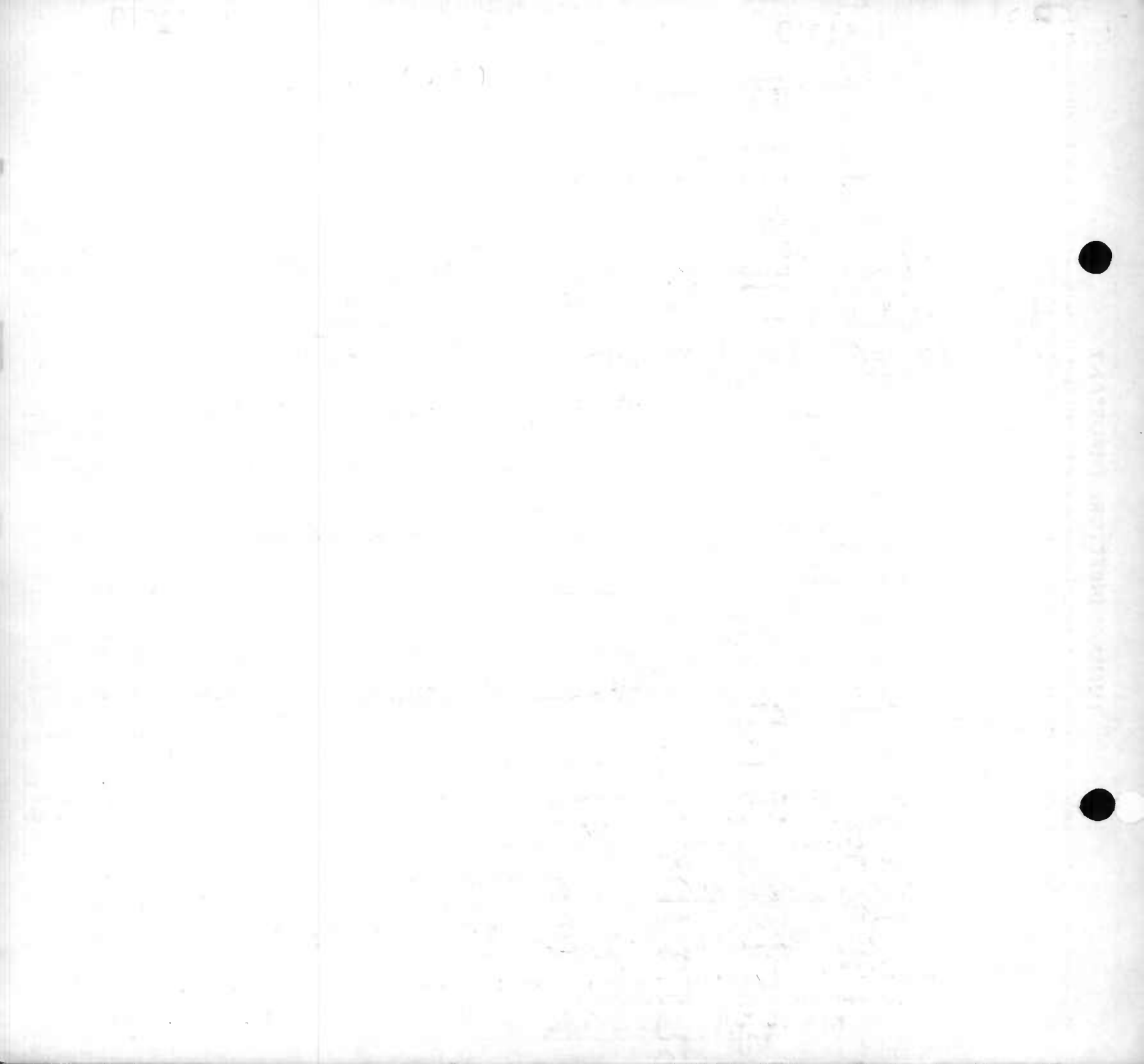
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11010

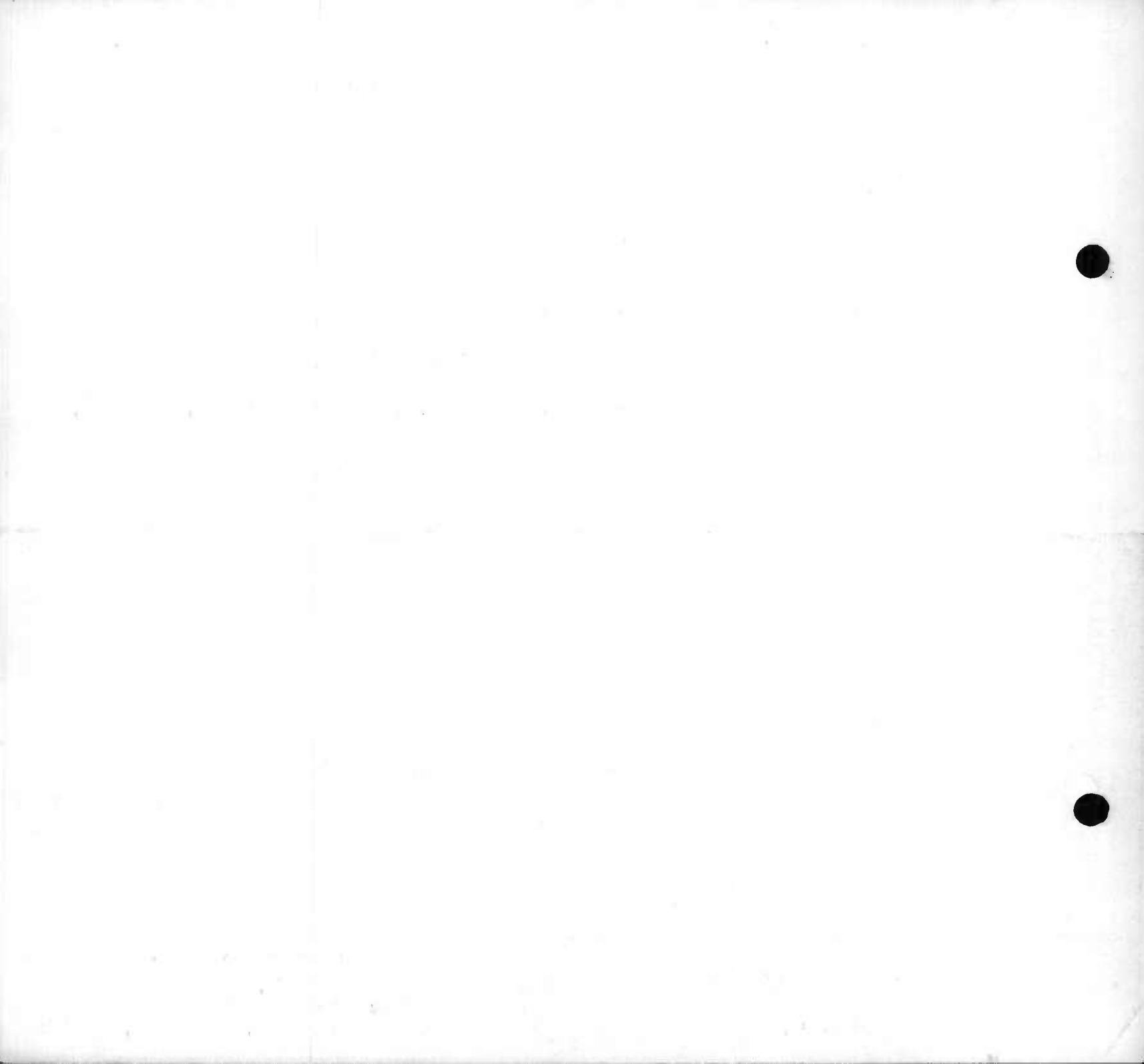
BIRTH NO. 71 11010		1. NAME OF DECEASED (Type or Print) GEORGE THOMAS (JR.)		2. DATE AND HOUR OF DEATH 11/25 732	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1202			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44		C. CITY OR TOWN Balt.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3333 N. Charles	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/95	9. AGE (In years last birthday) 26	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refined		10B. KIND OF BUSINESS OR INDUSTRY State of Md.		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Dr. GEORGE THOMAS		14. MOTHER'S MAIDEN NAME LEIZABETH M. HAMMOND	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW 1		16. SOCIAL SECURITY NO. 214-14-8353		17. INFORMANT Record U.M.H.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 153.8 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca lung & liver (B) Adenocarcinoma colon (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos. 2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not-While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11/25/71 to 11/25/71 and that (1) (we) last saw the deceased alive on 11/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Whithersy M.D.		23B. DATE SIGNED 11/25/71		23C. PHYSICIAN'S NAME (Type) Philip Whithersy M.D.	
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 11/29/71		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		24E. ADDRESS 108 W. North		24F. ADDRESS 108 W. North	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farley, Jr.		25C. FUNERAL DIRECTOR STEWART & MOWEN CO.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11011	
BIRTH NO. 71 11011					
1. NAME OF DECEASED (Type or Print) PAUL E. CONKLIN			2. DATE AND HOUR OF DEATH 11/25/1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2711		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX M			6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President & SM			10B. KIND OF BUSINESS OR INDUSTRY Dutterer of Mchstr		8. DATE OF BIRTH 1-30-02
13. FATHER'S NAME Rush West Conklin			14. MOTHER'S MAIDEN NAME Florence Chipman		9. AGE (In years last birthday) 69
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II			16. SOCIAL SECURITY NO. 212-09-5642		11. BIRTHPLACE (State or foreign country) MD
17. INFORMANT Wife, 100 W Cold Spring Ln, Baltimore, Md			12. CITIZEN OF WHAT COUNTRY? USA		
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Obstructive Lung Disease - emphysema					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-14-71 19 71 to 11-25 19 71 that (I) (we) last saw the deceased alive on 11-25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Beltran, M.D.			23B. DATE SIGNED 11/25/71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) JUAN A. BELTRAN MD			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/71		24C. NAME OF CEMETERY OR CREMATORY Mount Comfort Cemetery	
24D. LOCATION (City, town, or county) (State) Alexandria, Virginia					
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farley, Jr.		25C. FUNERAL DIRECTOR Demaine Funeral Home, Alexandria, Virginia	



R 524

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11012

REG. NO. 71 11012

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Allen Ringley</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>November</u> Day <u>22</u> , Year <u>1971</u> Hour <u>M.</u>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>3221 Frederick Avenue</u> <u>(Pittsburg Paint & Glass Co.)</u>		3. DATE PRONOUNCED DEAD Month <u>November</u> Day <u>22</u> , Year <u>1971</u> Hour <u>4:25 P.</u>	
6. SEX <u>Male</u>		7. RACE <u>White</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u>	
9. DATE OF BIRTH <u>MAY 19 1939</u>		10. AGE (In years lost birthday) <u>32</u>	
11. BIRTHPLACE (State or foreign country) <u>JONESVILLE VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory worker</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>P.P.G. Co.</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>?</u>	
18. INFORMANT <u>Mrs. Violet Ringley</u>		19. ADDRESS <u>1300 Montgomery Rd. Elkridge, Md 21027</u>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. IMMEDIATE CAUSE <u>Multiple gunshot wounds of chest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION <u>11-22-71</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>2006</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Factory</u>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>3221 Frederick Ave. = Pittsburg Paint &</u>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <u>11-22-71 3:19 P.m.</u>	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Glass Company</u> <u>Shot during work by sniper fire</u>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 23, 1971 ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Werner U. Spetz, M.D.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-26-71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>LORRAINE PARK</u>		24D. LOCATION (City, town, or county) (State) <u>WOODLAWN Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Higinbotham-Slack F.H.</u>		25D. ADDRESS <u>Ellicott City Md 21043</u>	



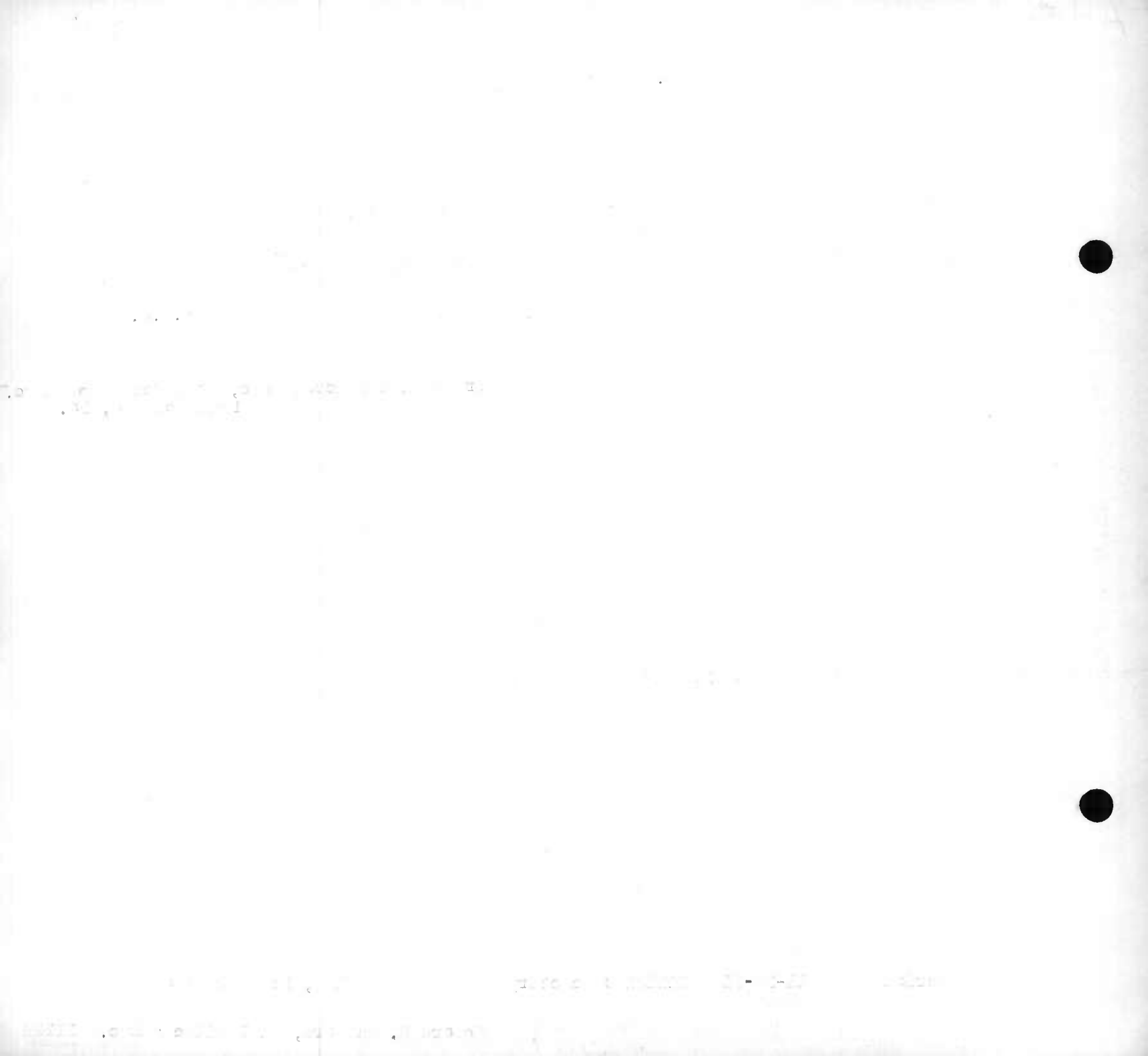
Mr. R. H. Ringley
St. Louis, Mo.
Dear Sir:

R. H. Ringley

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

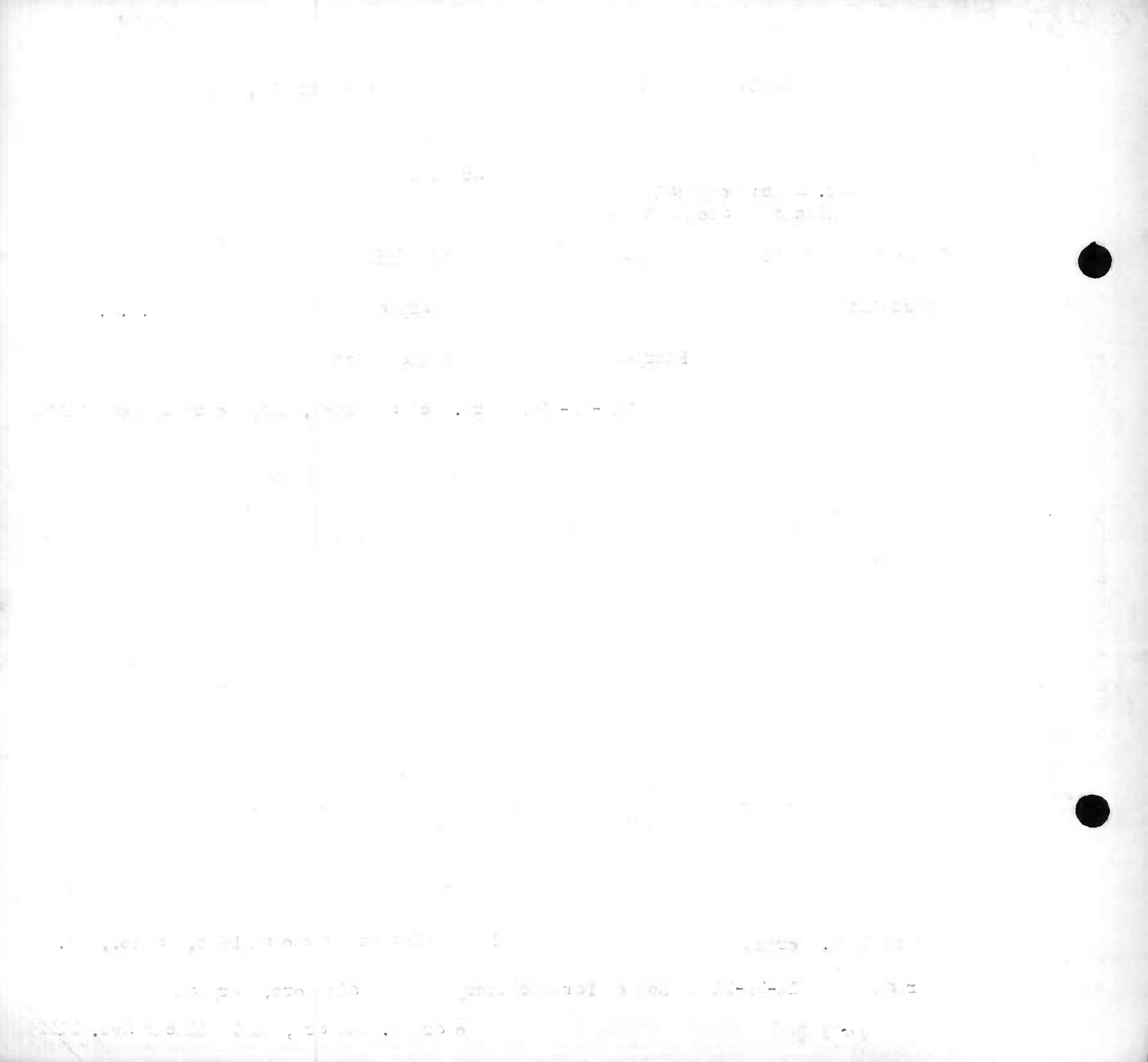
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11013
BIRTH NO. 71 11013				
1. NAME OF DECEASED (Type or Print) THELMA E. ALBRIGHT		2. DATE AND HOUR OF DEATH 11/26/71 9:54 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY MONTGOMERY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY of MD Hosp 22 S. GREEN ST #21201		C. CITY OR TOWN SILVER SPRING D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX F		E. STREET AND NUMBER 3024 BEL PRE RD APT #203		
6. RACE WHITE		8. DATE OF BIRTH 10/23/46		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 25		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		11. BIRTHPLACE (State or foreign country) PA.		
10B. KIND OF BUSINESS OR INDUSTRY DEPT of JUSTICE		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILEY K. FURR JR.		14. MOTHER'S MAIDEN NAME MARY MORTON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
		17. INFORMANT Kirk & Nice Funeral Home, 6301 Germantown Ave. Philadelphia, Pa. Hosp CHART		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 563.11		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Renal Failure (B) Septicaemia (C) Peritonitis		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Ulcerative Colitis		
19A. DATE OF OPERATION 11-18-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ulcerative Colitis		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR		21G. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from 11-23 19 71 to 11-26 19 71 that (I) (we) last saw the deceased alive on 11-26 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Gerald Crowley		23B. DATE SIGNED 11-26-71		23C. PHYSICIAN'S NAME (Type) CROWLEY
23D. ADDRESS		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-30-71		24C. NAME OF CEMETERY or CREMATORY Hillside Cemetery
24D. LOCATION (City, town, or county) (State) Roslyn, Pennsylvania		25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11014</u>	
BIRTH NO. <u>71 11014</u>		1. NAME OF DECEASED (Type or Print) BESSIE COLOMBO		2. DATE AND HOUR OF DEATH November 26, 1971 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Wilkins & Caton Avenues			C. CITY OR TOWN Arbutus		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX FEMALE			6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3/27/02			9. AGE (In years last birthday) 69 yrs		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Pierpont		
14. MOTHER'S MAIDEN NAME Julia Wise			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		
16. SOCIAL SECURITY NO. 218-05-1285			17. INFORMANT ADDRESS Mrs. Selma Horton, 1135 Courtney Road 21227		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic CARDIO-VASCULAR DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GENERALIZED Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS +
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 19 1963 to NOVEMBER 26 1971 that (I) (we) last saw the deceased alive on NOVEMBER 23 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin N. Borden M.D.				23B. DATE SIGNED NOVEMBER 26, 1971	
23C. PHYSICIAN'S NAME (Type) Melvin N. Borden				23D. ADDRESS 5000 Baltimore National Pike, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-29-71		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkins Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <u>71 11015</u>
BIRTH NO. <u>71 11015</u>		1. NAME OF DECEASED (Type or Print) <u>BLANQUETTE, HARRY P.</u>		2. DATE AND HOUR OF DEATH <u>11-26-71</u> <u>3:20</u> A.M.
CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u> ADDRESS OR LOCATION <u>12-8-71</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2831</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u>		6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-1893</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter & Dec.</u>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) <u>76</u> <u>XX</u>
13. FATHER'S NAME <u>Harry Blanquette</u>		14. MOTHER'S MAIDEN NAME <u>Flora -Rice- Fitz</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-7895</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
17. INFORMANT <u>Mr. Harry A. Blanquette, 812 Stamford Rd.</u>		ADDRESS <u>21229</u>		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CVA</u>				<u>4 days</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <u>DIABETES MELLITUS</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11-23</u> 19 <u>71</u> to <u>11-26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11-26</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.				
23A. SIGNATURE <u>Peter Oroszlan</u>		23B. DATE SIGNED <u>11-26-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>PETER OROSZLAN</u>		23D. ADDRESS <u>3 HAMILL RD 5, 21210</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-29-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>
24D. LOCATION <u>Washington Blvd. Howard Co. Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		24F. NAME OF REGISTRAR <u>Robert E. Sisk</u>
25A. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		25B. ADDRESS <u>4107 Wilkens Ave, 21229</u>		

V.S. 153

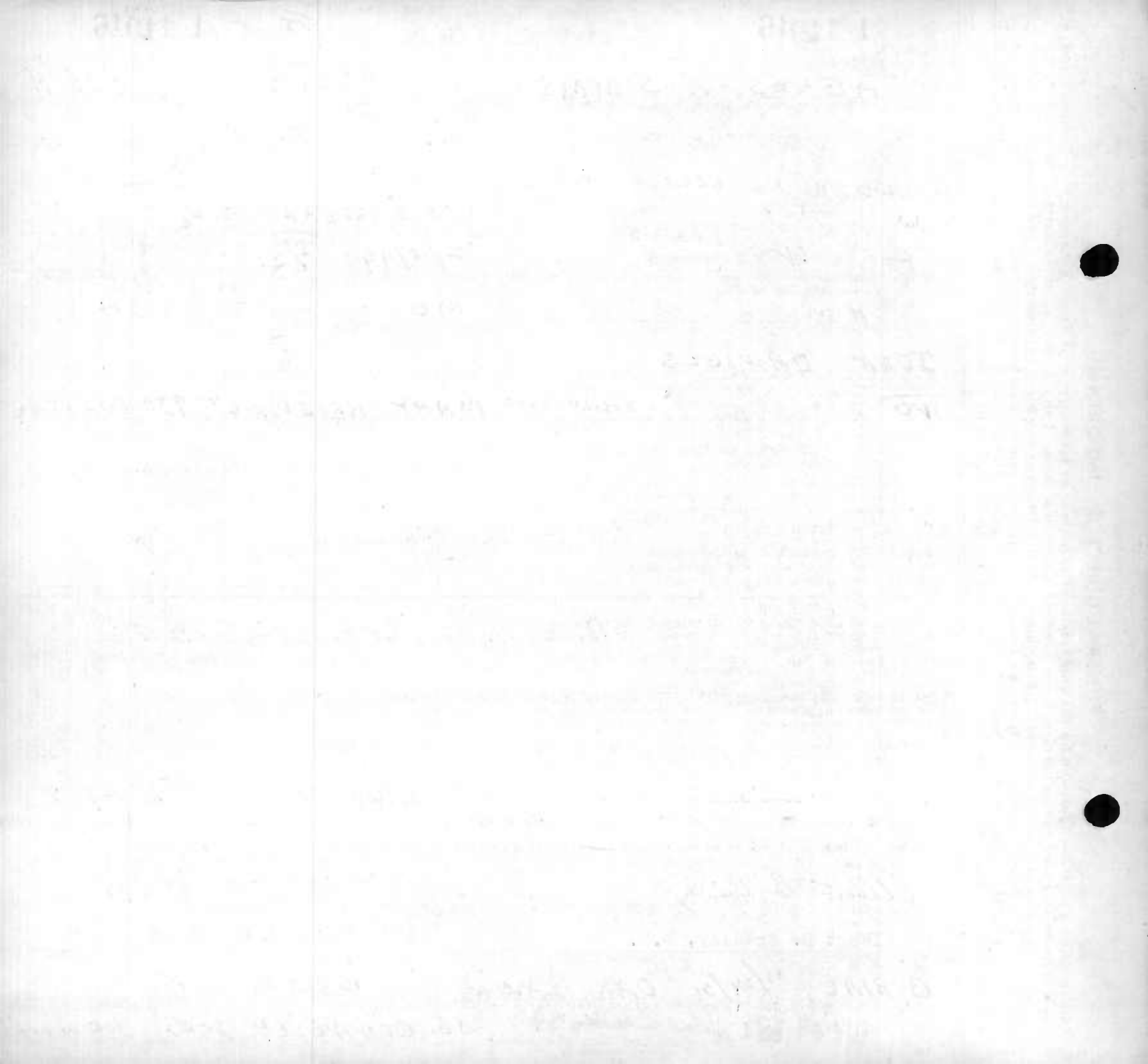
12-8-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11016	
<div style="display: flex; justify-content: space-between;"> 95201 71 11016 </div>					
BIRTH NO. 1. NAME OF DECEASED (Type or Print) AGNES K. SIMMS			2. DATE AND HOUR OF DEATH 11/24/71 5:35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOULD N. H. BELAIR RD 90			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTO. 5300 C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 531 EASTERN AVE		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/99	9. AGE (In years last birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.			11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN DANIELS			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-20-2600	17. INFORMANT MARY KROENING 930 QUANTAK		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 456.011 250.9 CAUSE OF DEATH Acute Coronary Arteriosclerosis Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes; Hypertension; Heart Failure; Urinary Tract Infection			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute Chronic ?		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/12/71 to 11/24/71, that (I) (we) last saw the deceased alive on 11/24/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.					
23A. SIGNATURE Albert B. Bradley			23B. DATE SIGNED 11/26/71		23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 11/29/71		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971			25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR J.G. CONNELLY SONS
25D. ADDRESS 4900 Belair Road 21206			25E. ADDRESS 300 MACE		



71 11017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11017

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WESLEY L. MC CORMICH JR.

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET

OR INSTITUTION

Police Boat "Interpid"

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

November 23, 1971

10:05 A.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

BALTO

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Essex
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9/10/47

10. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

927 Garden Drive, Apt. 1A

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WESLEY L. MC CORMICK SR

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PAINTER

14B. KIND OF BUSINESS OR INDUSTRY

CHEMCO

15. MOTHER'S MAIDEN NAME

MARY MACAULEY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

17. SOCIAL
SECURITY NO.

219-44-8990

18. INFORMANT

FATHER

ADDRESS

ABOVE

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Drowning
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

water

22C. WHERE DID (If in Baltimore City, give exact location)

Off President Street

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) ? ? ? m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR? Drove car overboard

Presumably jumped into water

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 23, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11/27/71

24C. NAME of CEMETERY or CREMATORY

OAK LAWN

24D. LOCATION (City, town, or county)

BALTO. MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

ADDRESS

300

12/21/71 - Letter from O.C.M.E., Werner Spitz, M.D.

Letter from M.C.E. to Office H.
12-1-71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 11018		71 11018	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Hopson, Ollie Bell</u>				2. DATE AND HOUR OF DEATH <u>11 / 28 / 71</u> <u>8:55 am</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>43</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>Maryland</u>		B. COUNTY <u>Baltimore</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2729 Seamon Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/1904</u>	9. AGE (in years last birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Fpps</u>				14. MOTHER'S MAIDEN NAME <u>Louisa</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>227-22-6131</u>		17. INFORMANT <u>chart</u>		ADDRESS	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrhythmia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) <u>Antero-lateral myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>Arteriosclerotic cardiovascular disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>nil</u>			
19A. DATE OF OPERATION <u>nil</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>nil</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>			
22. I certify that (4) (this hospital) attended the deceased from <u>11 / 24 / 71</u> <u>19 71</u> to <u>11 / 28 / 19 71</u> that (I) (we) last saw the deceased alive on <u>11 / 28 / 19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R. Sirthara</u>				23B. DATE SIGNED <u>11 / 28 / 71</u>		23C. PHYSICIAN'S NAME (Type) <u>SIRITHARA</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>11/30/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Family Plot</u>		24D. LOCATION (City, town, or county) (State) <u>Seamon Ave. D.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>S.P. Jones - Washington D.C.</u>		ADDRESS <u>Poe Memorial Plngs</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11019	
BIRTH NO. 71 11019					
1. NAME OF DECEASED (Type or Print) BRAD FORD, CASSIE ELLIS		2. DATE AND HOUR OF DEATH 11/27/71 7:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland GENERAL HOSPITAL 48		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 502 ROBERT ST.					
5. SEX (F)	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/8/23	9. AGE (In years last birthday) 48	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MD - BALTO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOHN BRAYTON		14. MOTHER'S MAIDEN NAME CARRIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Mary Stoeckel / 840 Druid Hill Ave	
18. 238.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RECURRENT BRAIN TUMOR - ? ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION JUNE 71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) NO		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO	
22. I certify that (I) (this hospital) attended the deceased from 11/11/71 to 11/27/71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold J. Kaplan M.D.				23B. DATE SIGNED 11/27/71	
23C. PHYSICIAN'S NAME (Type) HAROLD J. KAPLAN MD				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 12/7/71		24C. NAME OF CEMETERY OR CREMATORY Mt Airy	
24D. LOCATION BALTO MD					
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Fahey R.D.		25C. FUNERAL DIRECTOR Mary Stoeckel / 840 Druid Hill Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B 630 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 11020

BIRTH NO. 71 11020

1. NAME OF DECEASED
(Type or Print)

Barrett Leonidas

2. DATE AND HOUR OF DEATH

11-16-71

30

1901

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mt. Sinai Nursing Home
4413 Park Heights Ave. 21215

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

6 N. Stricker St.

5. SEX

M.

6. RACE

Colored

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

8-8-00

9. AGE (In years last birthday)

71

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Harry Barnett

14. MOTHER'S MAIDEN NAME

Julia Hines

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

712.4 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Central Thrombosis, acute

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

atherosclerotic Heart Disease & arrhythmic fibrillation

(B) DUE TO, OR AS A CONSEQUENCE OF:

None

(C).....

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 days

1 year

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

None

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 15 1971 to Nov 16 1971 that (I) (we) last saw the deceased alive on Nov 16 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Manuel Levin M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

11/17/71

23C. PHYSICIAN'S NAME (Type)

MANUEL LEVIN

M.D.

23D. ADDRESS

6101 PARK HTS AVE BALTO -15 MD

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/19/71

24C. NAME of CEMETERY or CREMATORY

Western (Cemetery) Star

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

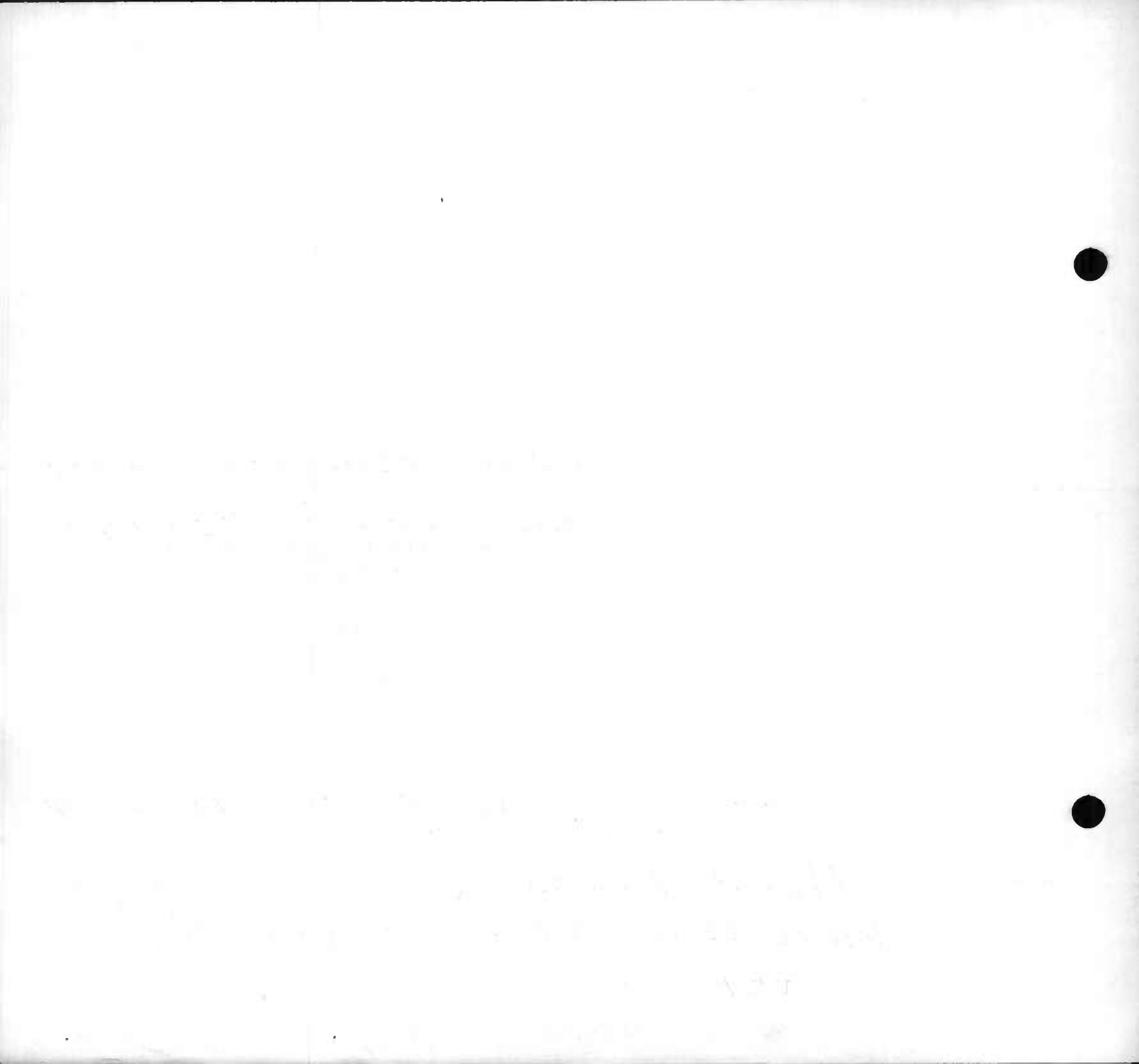
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Kenneth Law, 4611 Park Heights Ave.

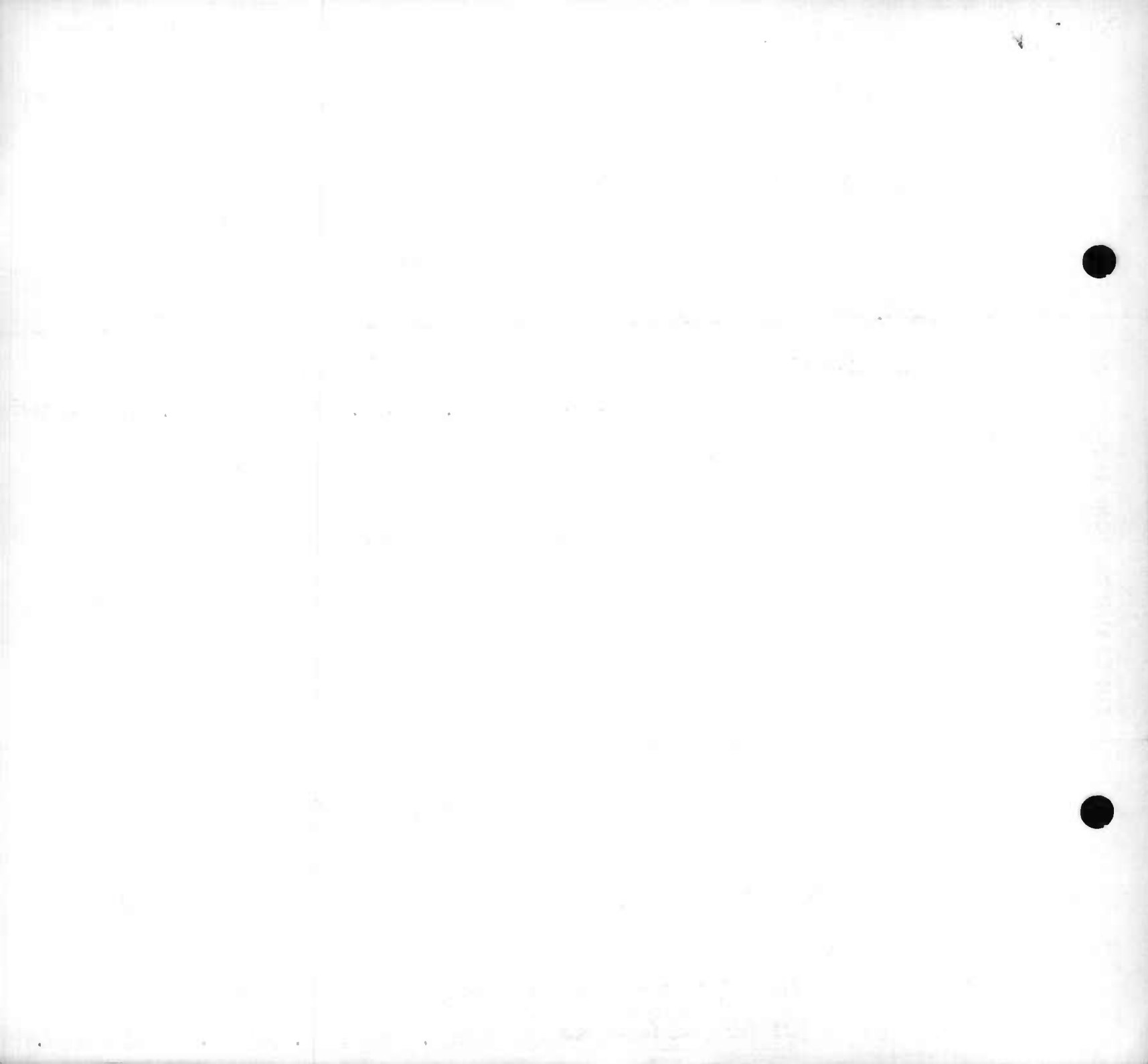
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11021</u>	
BIRTH NO. <u>71 11021</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>JOHN J. MILLER</u>			2. DATE AND HOUR OF DEATH <u>11/25/71</u> <u>11:35 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u> <u>48</u>			A. STATE <u>MD</u> B. COUNTY <u>702</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>518 N. KENWOOD AVE.</u> <u>21205</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/1898</u>	9. AGE (In years last birthday) <u>73</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>City Chevrolet</u>		11. BIRTHPLACE (State or foreign country) <u>M.D.</u>
13. FATHER'S NAME <u>Nicholas Mill</u>			14. MOTHER'S MAIDEN NAME <u>Connelia Winks</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-10-3729</u>		
			17. INFORMANT <u>Mrs. Rose M. Miller</u> ADDRESS <u>518 N. Kenwood Ave.</u>		
18. <u>410.9 I</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE (B) <u>Generalized arteriosclerosis</u> (C) <u>specially peripheral arteriosclerosis</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, room, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/15/71</u> 19 <u>71</u> to <u>11/25</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/25</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Beltran M.D.</u>				23B. DATE SIGNED <u>11/25/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JUAN A. BELTRAN</u>				23D. ADDRESS <u>MARYLAND GENERAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/27/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer Cemetery Baltimore, Maryland</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u> ADDRESS <u>3000 E. Baltimore St.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11022

BIRTH NO. 71 11022

1. NAME OF DECEASED
(Type or Print)

DOROTHY S. VOELKE

2. DATE AND HOUR OF DEATH

11/25/71 2:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital
48

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY

MD Baltimore 2610

C. CITY OR TOWN

BALTO.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

425 N. BOWDIN ST

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

04-30-97

9. AGE (In years last birthday)

74

10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

NO

11. BIRTHPLACE (State or foreign country)

XXXXX Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Benson

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Patients CHART

ADDRESS

18.

412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: UREMIA; RESPIRATORY FAILURE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) ASCVD; OHE

(C) CVA; Colostomy 2nd to

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

AmoRECTAL Fistula

19A. DATE OF OPERATION

10/28/71

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

AmoRECTAL Fistula

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

NO

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

NO

21D. TIME OF INJURY (APPROX.)

NO

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR?

NO

22. I certify that (I) (this hospital) attended the deceased from 10/18/71 to 11/20/71 and that (I) (we) last saw the deceased alive on 11/25/71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harold J. Kaplan

MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/25/71

23C. PHYSICIAN'S NAME (Type)

HAROLD J. KAPLAN

MD

23D. ADDRESS

Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/29/71

24C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

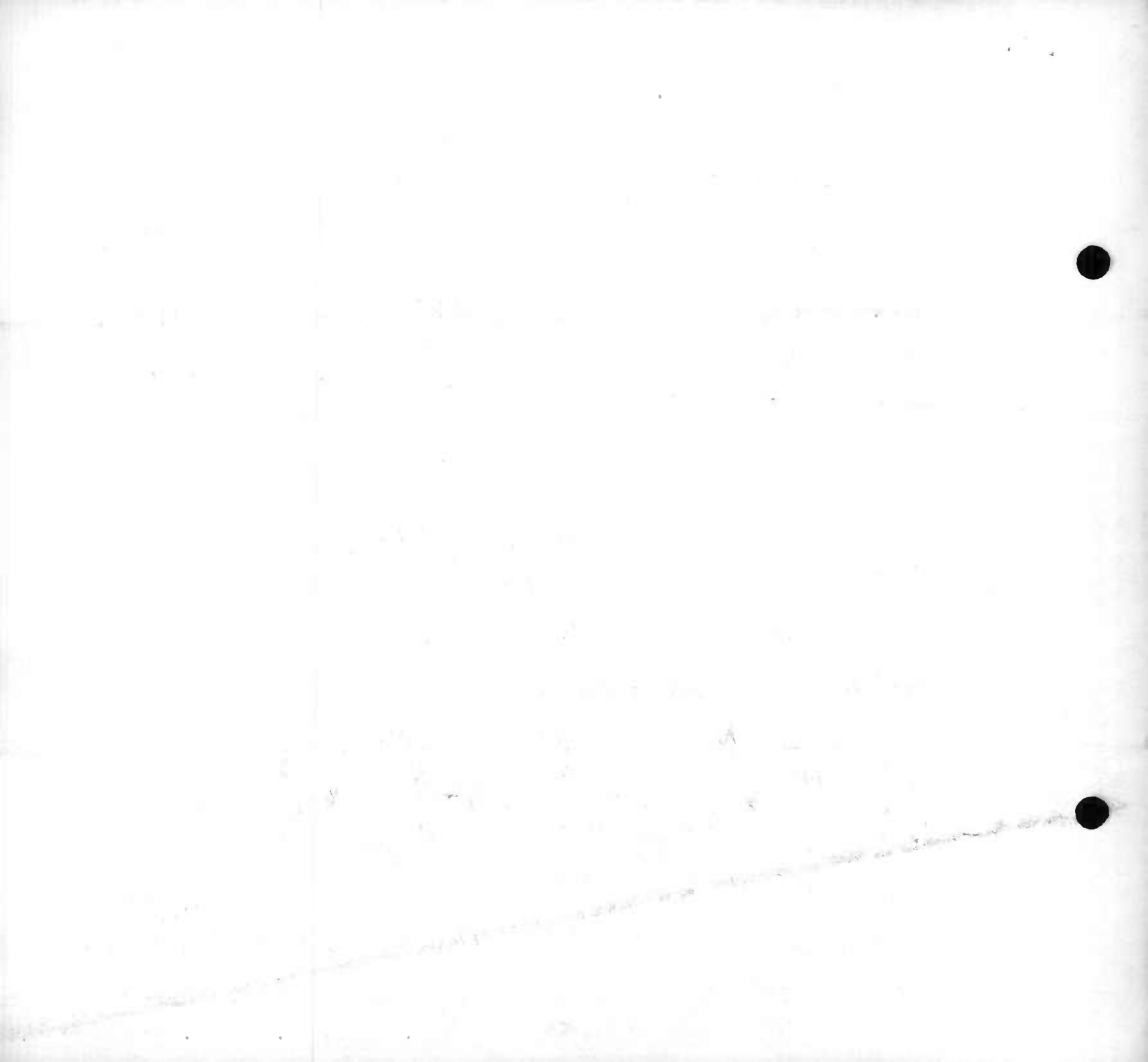
Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

John A. Moran, Inc.

ADDRESS

3000 E. Baltimore St.



D515

71 11023

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11023

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Martha ALMA DEMBINSKY		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> 11 28 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 28 1971 3:35p M.	
6. SEX female		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12/19/94		10. AGE (in years lost birthday) 76 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		15. MOTHER'S MAIDEN NAME Grimm	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Charles Dembinsky		ADDRESS 2831 Indiana Ave.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-29-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/1/71	
24C. NAME of CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue		ADDRESS 21228	

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11024

BIRTH NO. 71 11024

1. NAME OF DECEASED (Type or Print) DR. MAQBOOL WARRACH (WARAICH)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 470 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 27 1971 6:50 P M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1606		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3/1/47	10. AGE (In years lost birthday) 24	11. BIRTHPLACE (State or foreign country) PAKISTAN	
12. CITIZEN OF WHAT COUNTRY? PAKISTAN		13. FATHER'S NAME FAZAL HUSSAIN CHAUDHARY	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M.D.		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 214-68-4244	
18. INFORMANT ABDUL MEMON		ADDRESS 730 Ashburton St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple traumatic injuries (crushed chest) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway	
22C. WHERE DID INJURY OCCUR? Rt. 29		22D. HOW DID INJURY OCCUR? Passenger in auto-auto accident.	
22E. TIME (Month) (Day) (Year) (Hour) (Approx.) 11-27-71 5:47 P		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 11-28-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 11/30/71	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Gujrat, W. PAKISTAN	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Witzke		ADDRESS 1630 Edmondson Ave - BALTO, MD 21218	

1901-12-11

(1901-12-11)

1901-12-11

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11025

71 11025

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Mary Rhodes		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour	
				11	25	71	9:35 p.m.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 201		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX female	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 2018 E. Pratt St.			
9. DATE OF BIRTH JAN 24 1938	10. AGE (In years last birthday) 33	11. BIRTHPLACE (State or foreign country) CATON VILLE MD		12. CITIZEN OF WHAT COUNTRY? USA			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		13. FATHER'S NAME GOLDIE HUBBLE		15. MOTHER'S MAIDEN NAME MARGARET WILLIAMSON			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 216-36-7397		18. INFORMANT ADDRESS DELMIA RHODES 2018 E PRATT ST.			
19. 4124		CAUSE OF DEATH Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2/2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 11/26/71	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/29/71		24C. NAME OF CEMETERY or CREMATORY Mt CARMEL CEMETERY		24D. LOCATION (City, town, or county) (State) ODONNELL ST BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR ADDRESS THE DIPPEL BROS INC 800 E LOMBARD ST			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11026

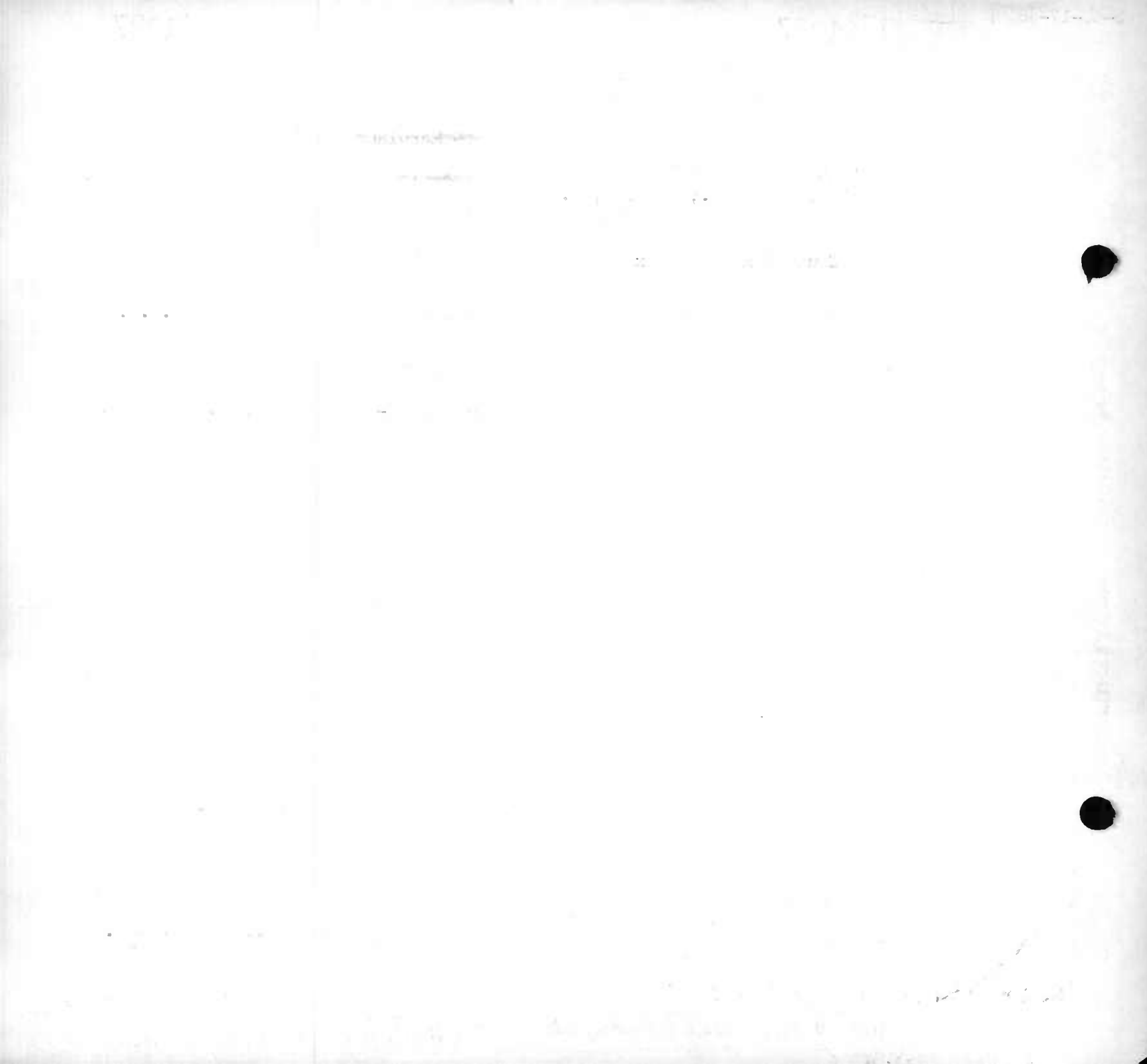
BIRTH NO. 71 11026		1. NAME OF DECEASED (Type or Print) <u>KAYEL, BLANCHE L.</u>		2. DATE AND HOUR OF DEATH <u>Nov 25, 1971</u> <u>3</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNIO N MEMORIAL HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>02-28-86</u> 9. AGE (In years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>GRANT MICHAELS</u>		14. MOTHER'S MAIDEN NAME <u>WILT MARY (D)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-50-3136</u>		17. INFORMANT <u>CHART</u> ADDRESS <u>-</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>486X I</u> CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>-</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia 122</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>-</u>		(C) <u>-</u>			
19A. DATE OF OPERATION <u>11-29-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> 19 <u>71</u> to <u>Nov 25</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Nov 25</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>11/25/71</u>		23C. PHYSICIAN'S NAME (Type) <u>TULLO BERTONIO</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/29/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>WOODLAWN</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Paul C. Charney</u>		25D. ADDRESS <u>3617 Chestnut Ave</u>			

2-8-2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
L6521 11027		71 11027		71 11027	
1. NAME OF DECEASED (Type or Print) LAWRENCE, FLOSSIE I		2. DATE AND HOUR OF DEATH 11/26/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals		C. CITY OR TOWN Danville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
31 4940 Eastern Ave., Baltimore, Md. 21224		E. STREET AND NUMBER 1919 Kelmere Road		21222	
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/01	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME YKN.		14. MOTHER'S MAIDEN NAME YKN.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216/10/7946		17. INFORMANT Records: BCH-4940 Eastern Avenue	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Breast Ca DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/25 19 71 to 11/26 19 71 that (I) (we) last saw the deceased alive on 11/26 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Malcolm H. Herring		23B. DATE SIGNED 11/26/71		23C. PHYSICIAN'S NAME (Type) Malcolm Herring	
23D. ADDRESS 4550 Eastern Ave.		23E. CITY OR TOWN Baltimore		23F. STATE Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-29-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
24D. LOCATION Balto.		24E. CITY OR TOWN Balto.		24F. STATE Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR McCully, 237 Patapsco Ave.	
25D. ADDRESS 21225		25E. CITY OR TOWN Balto.		25F. STATE Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

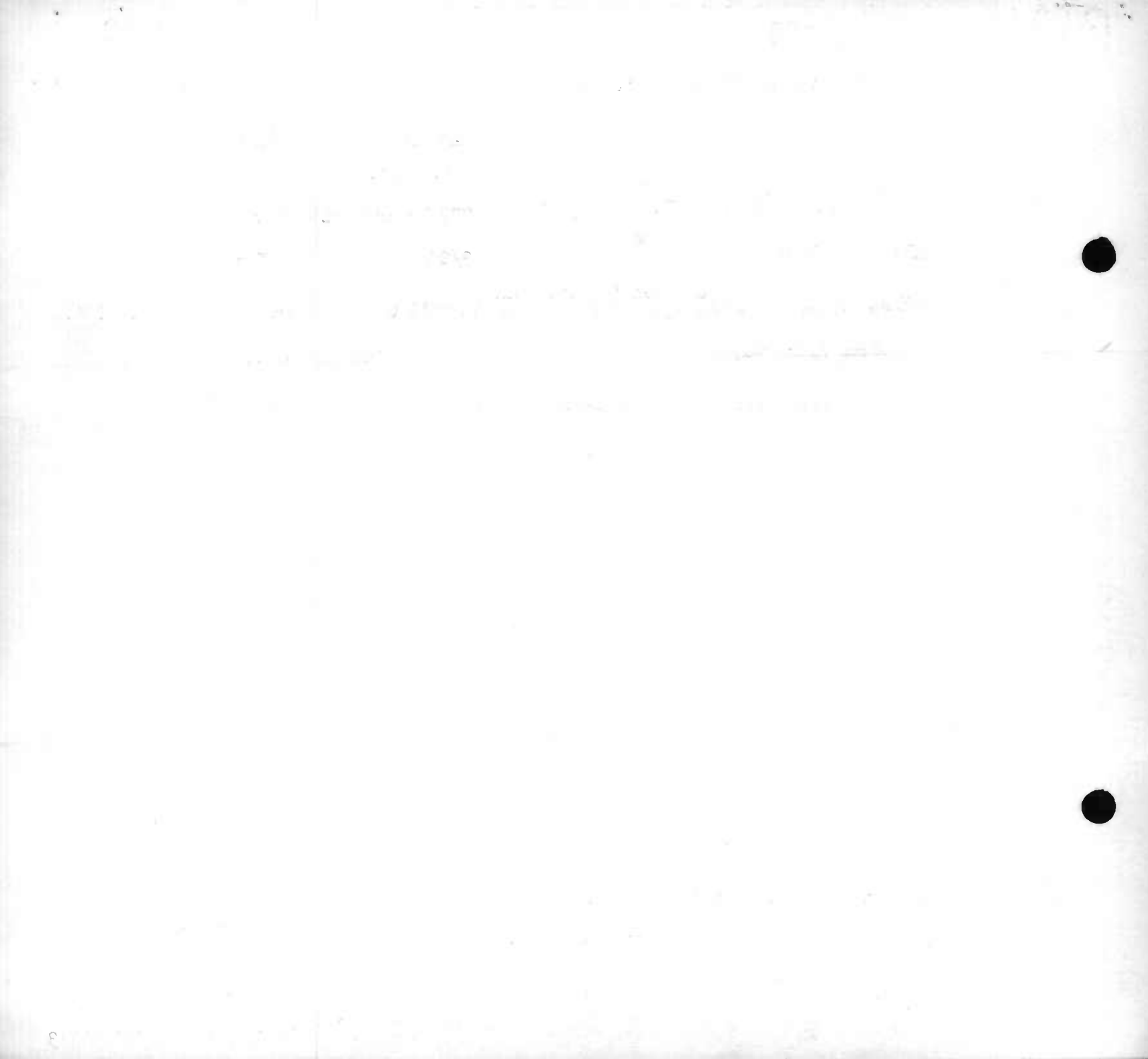
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11028	
BIRTH NO. 71 11028					
1. NAME OF DECEASED (Type or Print) MR. HILLGER, ALLEN		2. DATE AND HOUR OF DEATH Nov. 24th 1971 at 6:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Baltimore B. COUNTY 212151510			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3939 Penhurst St. (Haven nursing home)			
5. SEX M.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-24-1904	9. AGE (in years last birthday) 67yr
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FREDERICK HILLGER		14. MOTHER'S MAIDEN NAME LILLY FEIGE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. CARRA AMOSS, BAROET JR. MD. 81162	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 2884 IX		CAUSE OF DEATH (A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) fracture neck femur. DUE TO, OR AS A CONSEQUENCE OF: (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION —		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Nursing home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3939 Penhurst St. 15-18	
21D. TIME OF INJURY (APPROX.) 11/17/71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell out of bed	
22. I certify that (I) (this hospital) attended the deceased from 11-18-1971 to 11-24-1971 that (I) (we) last saw the deceased alive on 11-24-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Sampat		23B. DATE SIGNED 11-24-71			
23C. PHYSICIAN'S NAME (Type) J. SAMPAT, M.D.		23D. ADDRESS Lutheran Hospital of Md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 27 Nov 71		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEMETERY	
24D. LOCATION BALTO, MD.					
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR CLERICH FUNERAL HOME, BALTO, MD.	

Adm. N.H. 7/16/71
Prev. in Springfield Hosp
for 30 yrs.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11029	
BIRTH NO. 71 11029		1. NAME OF DECEASED (Type or Print) George Edward Berwager		2. DATE AND HOUR OF DEATH 11/26/71 10:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		Baltimore		5300	
34 BON SECOURS HOSPITAL		Pikesville		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Bon Secour Hospital, Baltimore, Md.		E. STREET AND NUMBER		735 Howard Road, 21208			
5. SEX Male <input checked="" type="checkbox"/>	6. RACE White <input checked="" type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/20/06		9. AGE (In years last birthday) 65 Yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FROM CHANNEL 67 T.V. STATION		10B. KIND OF BUSINESS OR INDUSTRY Channel 67 T.V. Sta.		11. BIRTHPLACE (State or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John S. Berwager				14. MOTHER'S MAIDEN NAME Sabina Sherman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-8359		17. INFORMANT ADDRESS Mrs. Marguerite Berwager, 735 Howard Rd. 21208			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)				Acute massive myocardial infarct days			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Occlusion of coronary artery days			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) no		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/21/71 to 11/26/71 and that (I) (we) lost the deceased alive on 11/26/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Arvoranee Bichaironarong Songgram M.D.				23B. DATE SIGNED 11/26/71			
23C. PHYSICIAN'S NAME (Type) Arvoranee Bichaironarong Songgram M.D.				23D. ADDRESS Bon Secours Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/71		24C. NAME OF CEMETERY OR CREMATORY Emory Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Upperco, Carroll County, Md. 21155	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Jarvey, M.D.		25C. FUNERAL DIRECTOR Loring Byers Funeral Directors P.A. 8728 Liberty Rd. Randallstown, Md. 21133			



S 500

71 11030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11030

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Howard F. Shomo

2. DATE AND HOUR OF DEATH

11/27/71

1:55 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md

AA

5200

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)South Baltimore General Hospital
43

C. CITY OR TOWN

Glen Burnie

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

6670 Robert Ct Code 21061

5. SEX

Male

6. RACE

white

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3/2/07

9. AGE (in years
last birthday)

64

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

British-American Properties

10B. KIND OF BUSINESS OR INDUSTRY

retired

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Howard (dec)

14. MOTHER'S MAIDEN NAME

Sadie Eppting (dec)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

wife - same as # 4

ADDRESS

18.

412.4 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CVA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(C)

Chronic Bronchitis.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Chronic Bronchitis.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 16th 1971 to November 27th 1971
that (I) (we) last saw the deceased alive on November 27th 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11/27/71

23C. PHYSICIAN'S
NAME (Type)

Dr. Cesar Hidalgo

23D. ADDRESS

South Baltimore General Hospital.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-30-71

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem. Ba Ho.

24D. LOCATION

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

Robert E. Sailer, M.D.

25C. FUNERAL DIRECTOR

McCully - 237 Patapsco Ave.

ADDRESS

21225

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

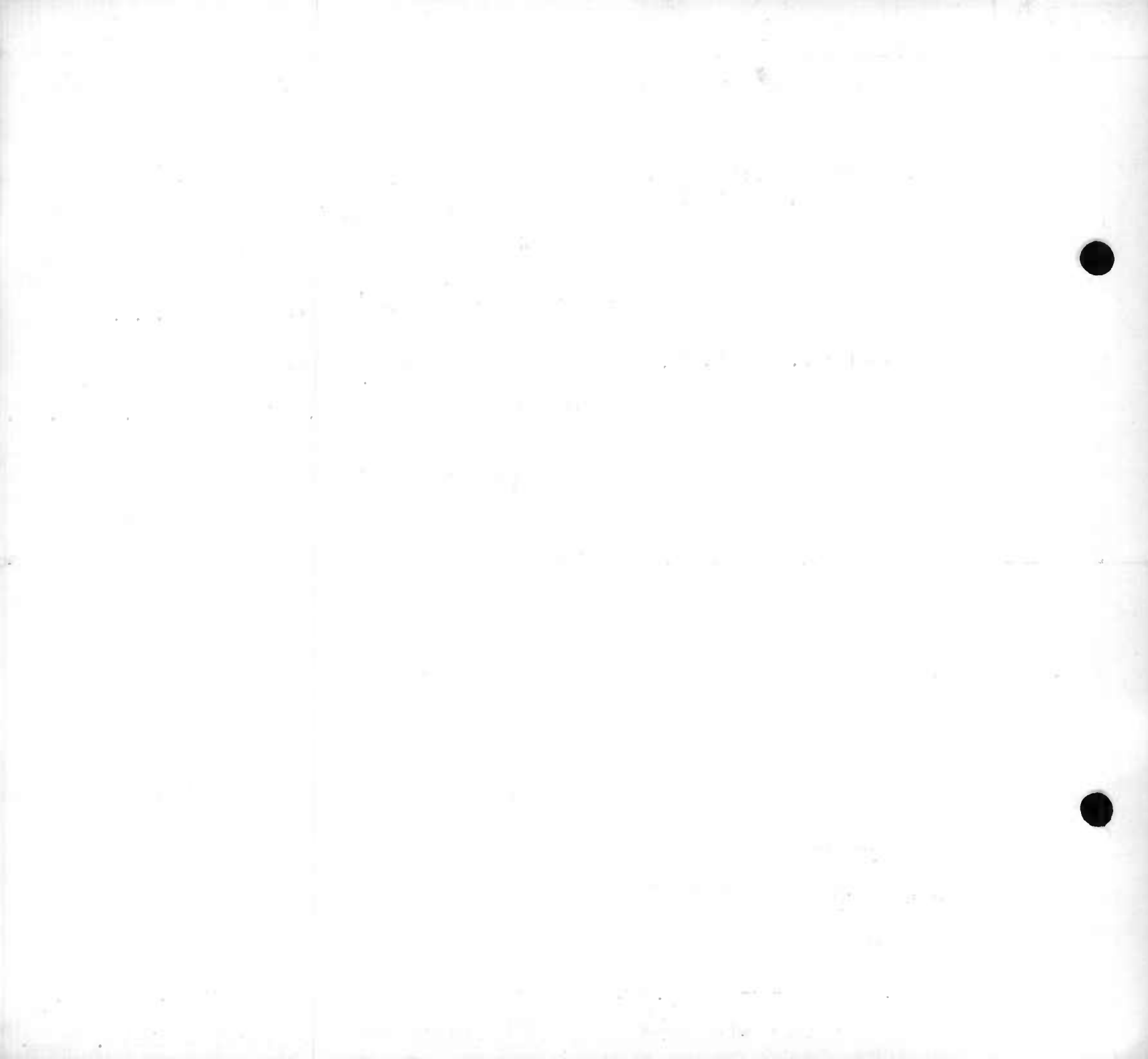
00021

00021

FUNERAL DIRECTOR: IMPORTANT

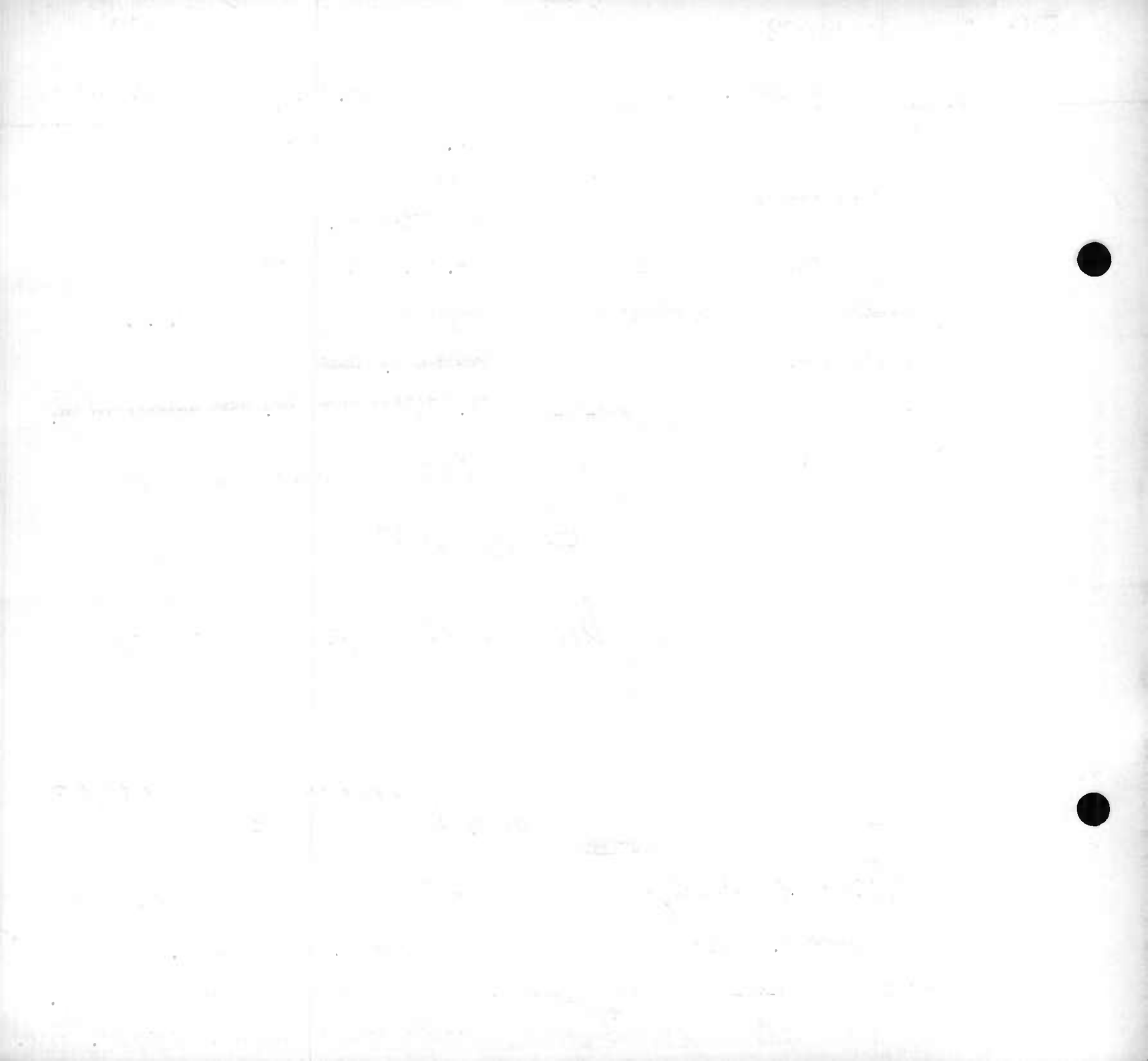
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11031</u>
BIRTH NO. <u>71 11031</u>		1. NAME OF DECEASED <u>THOMAS JOSEPH GERST</u>		
2. DATE AND HOUR OF DEATH <u>11/28/71</u> <u>12:30 AM</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		E. STREET AND NUMBER <u>9836 MAGLEDT ROAD</u>		
10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>11/27/71</u> 9. AGE (in years last birthday) <u>71 HRS</u>		
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>13</u> <u>30</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>WILLIAM J. GERST, JR.</u>		14. MOTHER'S MAIDEN NAME <u>MARY SUE MCGUIGAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>William Gerst, Jr. 9836 Magledt Rd. Balto. Md. 21234</u>
18. <u>71-2-1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Distress Synd</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Prematurity (30 weeks gestat)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u>
19A. DATE OF OPERATION <u>11/28/71</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR
22. I certify that (I) (this hospital) attended the deceased from <u>11/27/71</u> 19 <u>71</u> to <u>11/28/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Michael V. Johnston, MD</u>		23B. DATE SIGNED <u>11/28/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL V. JOHNSTON M.D.</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL, Balt. Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-30-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Joseph Cemetery</u>
24D. LOCATION <u>Fullerton</u>		<u>Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Rd. Balto. 21236</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

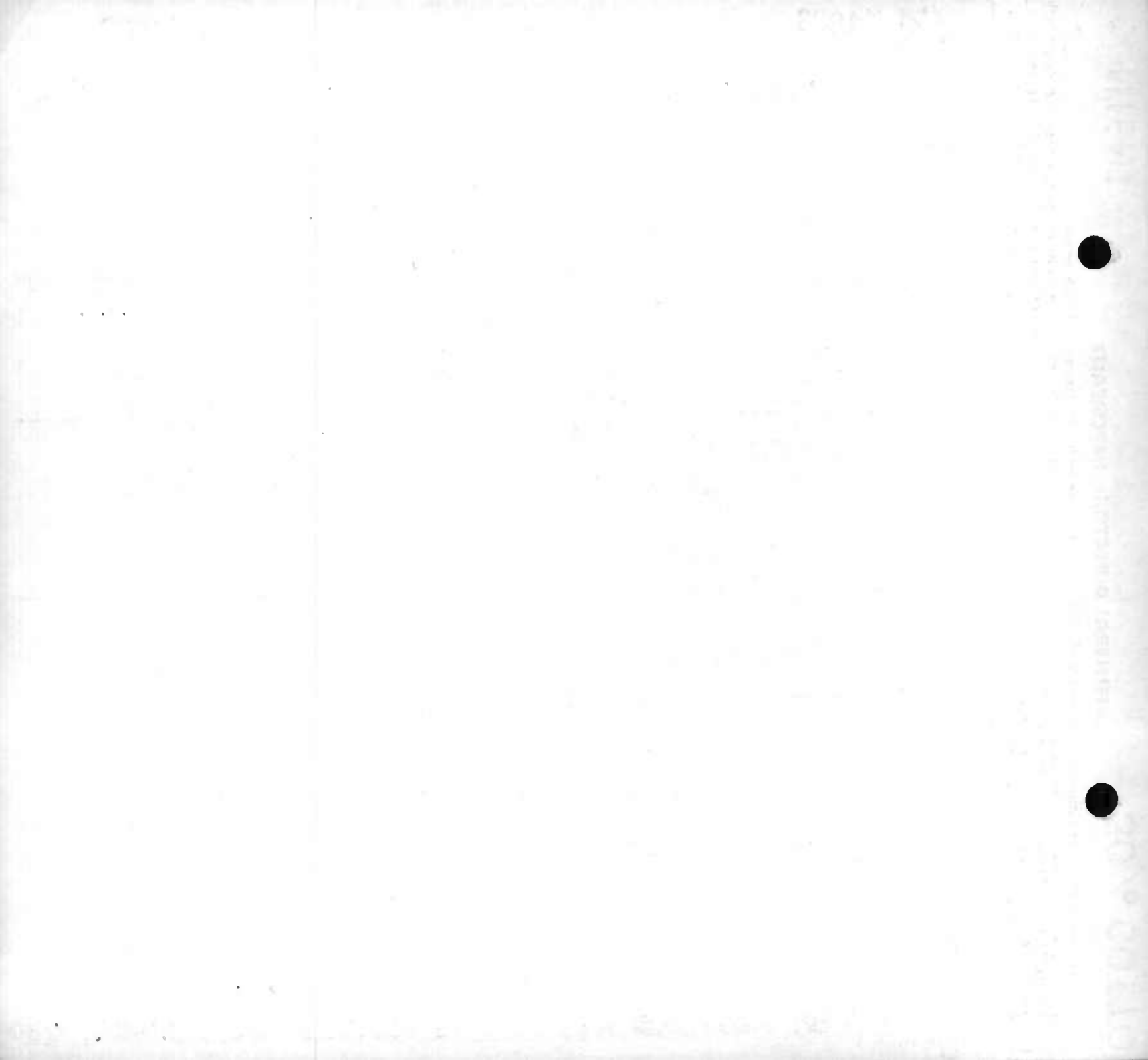
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11032</u>	
BIRTH NO. <u>71 11032</u>					
1. NAME OF DECEASED (Type or Print) <u>Amelia C. Bark</u>			2. DATE AND HOUR OF DEATH <u>Nov. 20, 1971</u> <u>11:20 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Gould Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Perry Hall</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>9100 Smith Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30, 1891</u>	9. AGE (In years last birthday) <u>79</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Homekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Frederick Frey</u>			14. MOTHER'S MAIDEN NAME <u>Pauline C. Eckas</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-7179</u>		17. INFORMANT ADDRESS <u>Mr. William Bark, Jr., 8618 Goldenwood Rd. 21237</u>	
18. <u>412.3Y1 25019</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes mellitus; Chronic Heart Disease; Stroke</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> <u>yes</u> <u>yes</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/19/71</u> to <u>11/20/71</u> that (I) (we) last saw the deceased alive on <u>11/19/71</u> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Albert B. Bradley</u>			23B. DATE SIGNED <u>11/22/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley</u>			23D. ADDRESS <u>4900 Belair Rd. Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-23-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>	
24D. LOCATION <u>Belair</u>		24E. CITY, TOWN, OR COUNTY <u>Harford</u>		24F. STATE <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>	
				ADDRESS <u>7401 Belair Rd. Balto. 21236</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 11033				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11033	
1. NAME OF DECEASED (Type or Print) Moon, John E.				2. DATE AND HOUR OF DEATH Nov. 28, 1971 1:30 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore, Maryland B. COUNTY 2404			
5. SEX Male				6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 23, 1898				9. AGE (In years last birthday) 73		10. IF Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Moon				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mable Moon 1518 William Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.91 CAUSE OF DEATH A. CARDIORESPIRATORY ARREST B. Congestive Heart Failure C. IMMEDIATE CAUSE DIABETES MELLITUS with GANGRENE DUE TO, OR AS A CONSEQUENCE OF: OF RIGHT FOOT - Months - years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
21A. DATE OF OPERATION 11-2-71		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE Rt Foot		21C. WHERE DID INJURY OCCUR? No		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct. 22 19 71 to Nov 28 19 71 that (I) (we) last saw the deceased alive on Nov 28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Benedict A. Termini MD.				23B. DATE SIGNED 11/28/71		23C. PHYSICIAN'S NAME (Type) BENEDICT A. TERMINI MD.	
23D. ADDRESS Mercy Hospital				23E. DATE REC'D BY HEALTH DEPT. NOV 30 1971		23F. NAME OF REGISTRAR Robert E. Taylor	
23G. DATE REC'D BY HEALTH DEPT. NOV 30 1971				23H. NAME OF REGISTRAR Robert E. Taylor		23I. FUNERAL DIRECTOR McCully Funeral Home 130 XXXXXXXX E. Fort	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/2/71		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION Baltimore, Md.				24E. DATE REC'D BY HEALTH DEPT. NOV 30 1971		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. DATE REC'D BY HEALTH DEPT. NOV 30 1971				24H. NAME OF REGISTRAR Robert E. Taylor		24I. FUNERAL DIRECTOR McCully Funeral Home 130 XXXXXXXX E. Fort	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

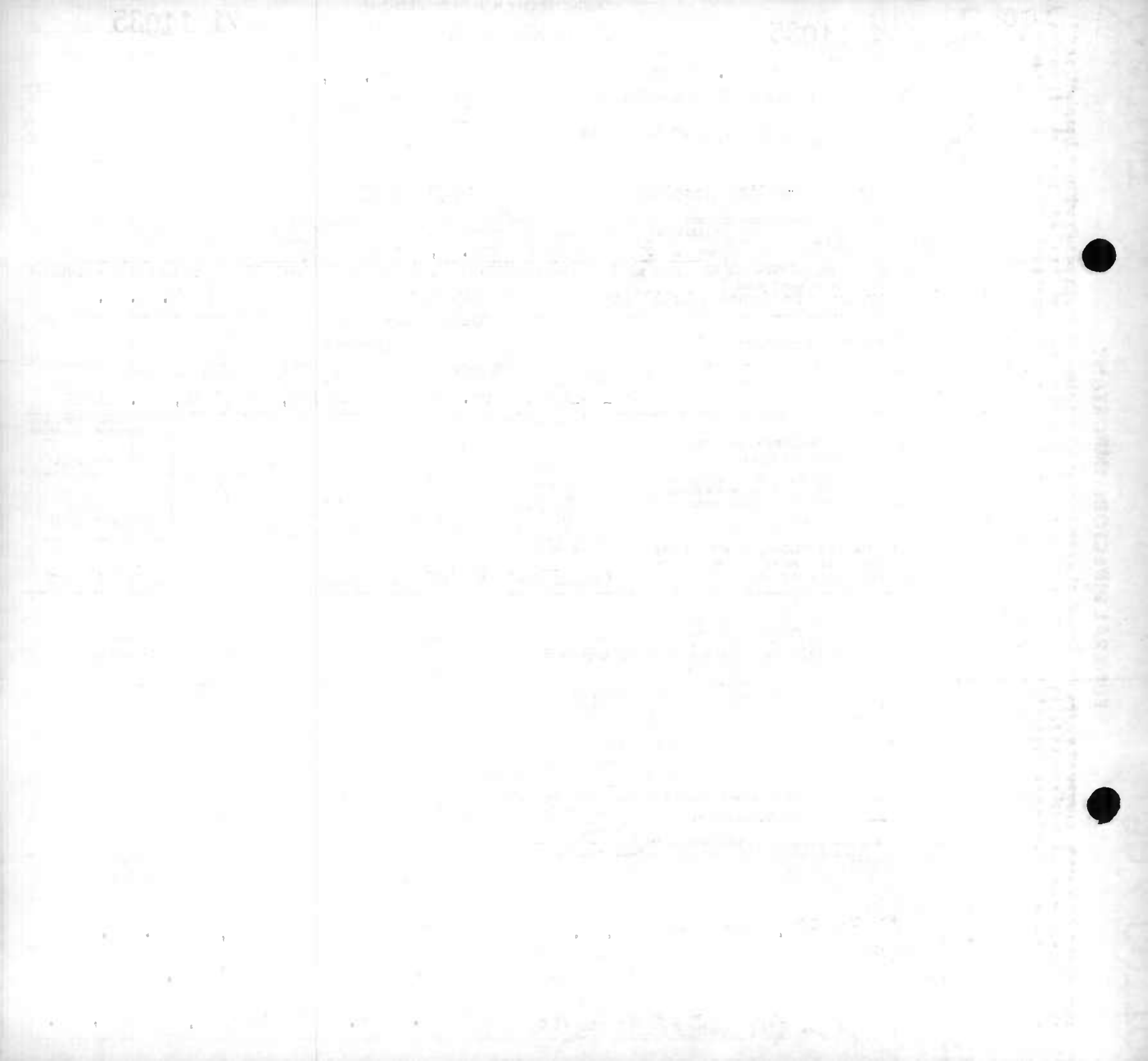
<p>71 11034</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 11034</p>	
<p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) ALBERT MARTIN GREENFIELD</p>	
<p>2. DATE AND HOUR OF DEATH 11-27-71 10 A.</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 1511</p>		<p>5. SEX Male 6. RACE White</p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 2-21-1892 9. AGE (in years last birthday) 79</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) South Carolina</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Greenfield</p>		<p>14. MOTHER'S MAIDEN NAME Unknown</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes - WW2 - Army</p>		<p>16. SOCIAL SECURITY NO. 214-20-0512</p>	
<p>17. INFORMANT John Greenfield ADDRESS 4514 Dunland Rd</p>		<p>18. CAUSE OF DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Adeno-Carcinoma of stomach with Generalized Metastasis - 3 1/2 years</p>	
<p>(B) DUE TO, OR AS A CONSEQUENCE OF: Generalized Metastasis - 2 years</p>		<p>(C) Arterio-Sclerotic Heart Disease - 5 years</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION 0 10</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from Jan. 27 19 61 to 11/27/71 19 71 that (I) (we) last saw the deceased alive on Nov. 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Earl L. Chambers, M.D.</p>		<p>23B. DATE SIGNED 11/29/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) Earl L. Chambers, M.D.</p>		<p>23D. ADDRESS 100 - W. Cold Spring Baltimore - Md</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>		<p>24B. DATE 11-30-71</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Md</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Jaber, R.D.</p>	
<p>25C. FUNERAL DIRECTOR ARMACAST Funeral Chapel</p>		<p>ADDRESS 4600 Lib. Heights Ave</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 11035</u>	
BIRTH NO. <u>71 11035</u>				1. NAME OF DECEASED (Type or Print) <u>May E. Haase</u>		2. DATE AND HOUR OF DEATH <u>Nov. 24, 1971</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3442 Yorkway</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1892</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Line Worker National Distillery</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Distillery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13. FATHER'S NAME <u>Thomas Blackburn</u>				14. MOTHER'S MAIDEN NAME <u>Margaret</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-24-5530</u>		17. INFORMANT (Daughter) <u>3442 Yorkway</u> ADDRESS <u>Mrs. Ethel Woytowitz, Dundalk, Md. 21222</u>		
18. <u>410.01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>64</u> to <u>11-24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11-24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>John B. Littleton M.D.</u> DEGREE <u>M.D.</u> 23B. DATE SIGNED <u>11/26/71</u> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23C. PHYSICIAN'S NAME (Type) <u>John B. Littleton M.D.</u> 23D. ADDRESS <u>1012 Old North Point Road, Balto. Md.</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>11/29/71</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u> 25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u> 25C. FUNERAL DIRECTOR ADDRESS <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
CERTIFICATE OF DEATH					REG. NO. <u>71 11036</u>									
BIRTH NO. <u>71 11036</u>					1. NAME OF DECEASED (Type or Print) <u>GRANT CAMPBELL</u>					2. DATE AND HOUR OF DEATH <u>11-26-71</u> <u>7:45</u> P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u>					5. STREET AND NUMBER <u>5300</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u>					C. CITY OR TOWN <u>TIMONIUM</u>					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <u>MALE</u>					6. RACE <u>CAUC.</u>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <u>APRIL 3, 1904</u>					9. AGE (In years last birthday) <u>67</u>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NAVY PILOT</u>				
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>PETER J. CAMPBELL</u>				
14. MOTHER'S MAIDEN NAME <u>FRANCIS KELLY</u>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>214-03-4759</u>				
17. INFORMANT <u>MILDRED P. CAMPBELL</u>					ADDRESS <u>SAME AS # 4</u>					18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio-respiratory failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Brain Tumor metastasis</u>									
(C) _____														
II														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).														
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>No</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>11-27</u> 19 <u>71</u> to <u>11-26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11-26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										23A. SIGNATURE <u>Phician 7 J. J. J. MD</u>				
23B. DATE SIGNED <u>Nov. 26, 1971</u>					23C. PHYSICIAN'S NAME (Type) <u>Phician 7 J. J. J.</u>					23D. ADDRESS <u>Mercy Hospital, St Paul St.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>11/30/71</u>					24C. NAME of CEMETERY or CREMATORY <u>ST. MARYS CEMETERY</u>				
24D. LOCATION <u>GOVANS, BALTIMORE MD</u>					25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>					25B. NAME OF REGISTRAR <u>Robert E. J. J. MD</u>				
25C. FUNERAL DIRECTOR <u>Wm. Cook, Brooks</u>					ADDRESS <u>Towson Inc. Towson Md.</u>									

UNITED STATES

DEPARTMENT OF THE ARMY

WASHINGTON, D. C.

MAJ. GEN. FRANCIS KELLY
HEADQUARTERS
ARMY
WASHINGTON, D. C.

JOHN J. CAMPBELL

ARMY 1/30/51 ST. LOUIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11037	
BIRTH NO. 71 11037		1. NAME OF DECEASED (Type or Print) HENRY W. KLEIN	
2. DATE AND HOUR OF DEATH NOV 26 1971 3:00 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL 33 BALTO., MD.	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER # South Side Avenue, Phoenix, Md.		6. SEX M 7. RACE W 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12/14/19 10. AGE (In years last birthday) 72		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Joseph Klein 14. MOTHER'S MAIDEN NAME Anna Zinkham		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-12-8668 17. INFORMANT Barbara Klein ADDRESS JACKSONVILLE, MD.		18. 05819 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
(A) IMMEDIATE CAUSE MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF:		(B) ACUTE RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF:	
(C) SEPSIS		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 18 1971 to Nov 26 1971 and that (I) (we) last saw the deceased alive on Nov 26 1971 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Edward J. Feinglass, MD.		23B. DATE SIGNED Nov 26, 1971	
23C. PHYSICIAN'S NAME (Type) EDWARD FEINGLASS		23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-29-71	
24C. NAME of CEMETERY or CREMATORY JACKSONVILLE REFORMED		24D. LOCATION (City, town, or county) (State) JACKSONVILLE BAL. MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farber, MD.	
25C. FUNERAL DIRECTOR Wm. Cook-Brecks Towson Inc.		ADDRESS Towson, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11038	
BIRTH NO. 71 11038				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHARLES L. SOHL		2. DATE AND HOUR OF DEATH Nov. 26/71 7⁰⁵ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE 2841			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3814 MILFORD AVE 21207			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/1916	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE SEWER JAKESMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick, Md	
13. FATHER'S NAME Henry A Sohl		14. MOTHER'S MAIDEN NAME Crum		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 217-05 8253		17. INFORMANT MRS. HELEN SOHL	
18. 7 TO 1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARDIOGENIC SHOCK.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCTION		15 HR.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EDEMA.			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 25 19 71 to Nov 26 19 71 that (I) (we) last saw the deceased alive on Nov 26/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RAUL PINTO R PINTO				23B. DATE SIGNED Nov. 26/71	
23C. PHYSICIAN'S NAME (Type) RAUL PINTO		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-29-71		24C. NAME OF CEMETERY OR CREMATORY MT Olivet Cemetery - Baltimore, Md	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971			
25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR Armenian Funeral Chapel - 4600 Lib. Hgts. Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. **71 11039**

BIRTH NO. **71 11039**

1. NAME OF DECEASED (Type or Print) Anderson, Annie S.		2. DATE AND HOUR OF DEATH 11-24-71 5:30 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY 1002	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 849 MC ALEER CT.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-80
9. AGE (In years last birthday) 91		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10B. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE KANE		14. MOTHER'S MAIDEN NAME BARBARA MILLER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Howard Anderson		ADDRESS 8421 Loch Raven Blvd	
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Prob Pulmonary Embolus CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/24 19 71 to 11/24 19 71 that (I) was last saw the deceased alive on 11/24 19 71 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.			
23A. SIGNATURE L. E. Roubler MD		23B. DATE SIGNED 11/24/71	
23C. PHYSICIAN'S NAME (Type) L. E. Roubler MD		23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-27-71	
24C. NAME OF CEMETERY or CREMATORY FIRST UNITED EVANGELICAL Church Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Garber, M.D.	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks-Townson, Inc.		ADDRESS Towson, Md	

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BALTIMORE CITY HEALTH DEPARTMENT

71 11040

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11040

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Michael Anthony Perrera		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
				11	25	71	3:00 p. M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 5300		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
9. DATE OF BIRTH March 20, 1943	10. AGE (In years lost birthday) 28	11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Tony Perrera		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		15. MOTHER'S MAIDEN NAME Jean Williams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/15/60 to 10/4/63	
17. SOCIAL SECURITY NO. 215 40 2816		18. INFORMANT Joyce Perrera		19. ADDRESS 1235 Primrose Avenue			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOUSE		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1229 Angelsea Street 2636			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11 25 71 3:30 m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject stabbed during altercation.			
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-29-71		24C. NAME OF CEMETERY or CREMATORY Holly Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR		ADDRESS 1211 Chesaco Avenue	

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71 11041

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11041

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ELIZA J. ELIZABETH LEIGH

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1405 Park Ave. Apt. 15

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

11

28

1971

2:10 a

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE Md.

B. COUNTY

1401

6. SEX

female

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Nov. 20, 1922.

10. AGE (In years
last birthday)

49

11. Under 1 Yr. 11 Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1405 Park Ave. Apt. 15

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

John Stanley

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Anne Barbour

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL

SECURITY NO.

230-18-5281

18. INFORMANT

Mr. Walter H. Leigh

ADDRESS

(Same)

19.

41241

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-28-71

24A. BURIAL CREMATION,
REMOVAL (Specify)
Cremation

24B. DATE

12/1/71.

24C. NAME OF CEMETERY or CREMATORY

Greenmount Crematory

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

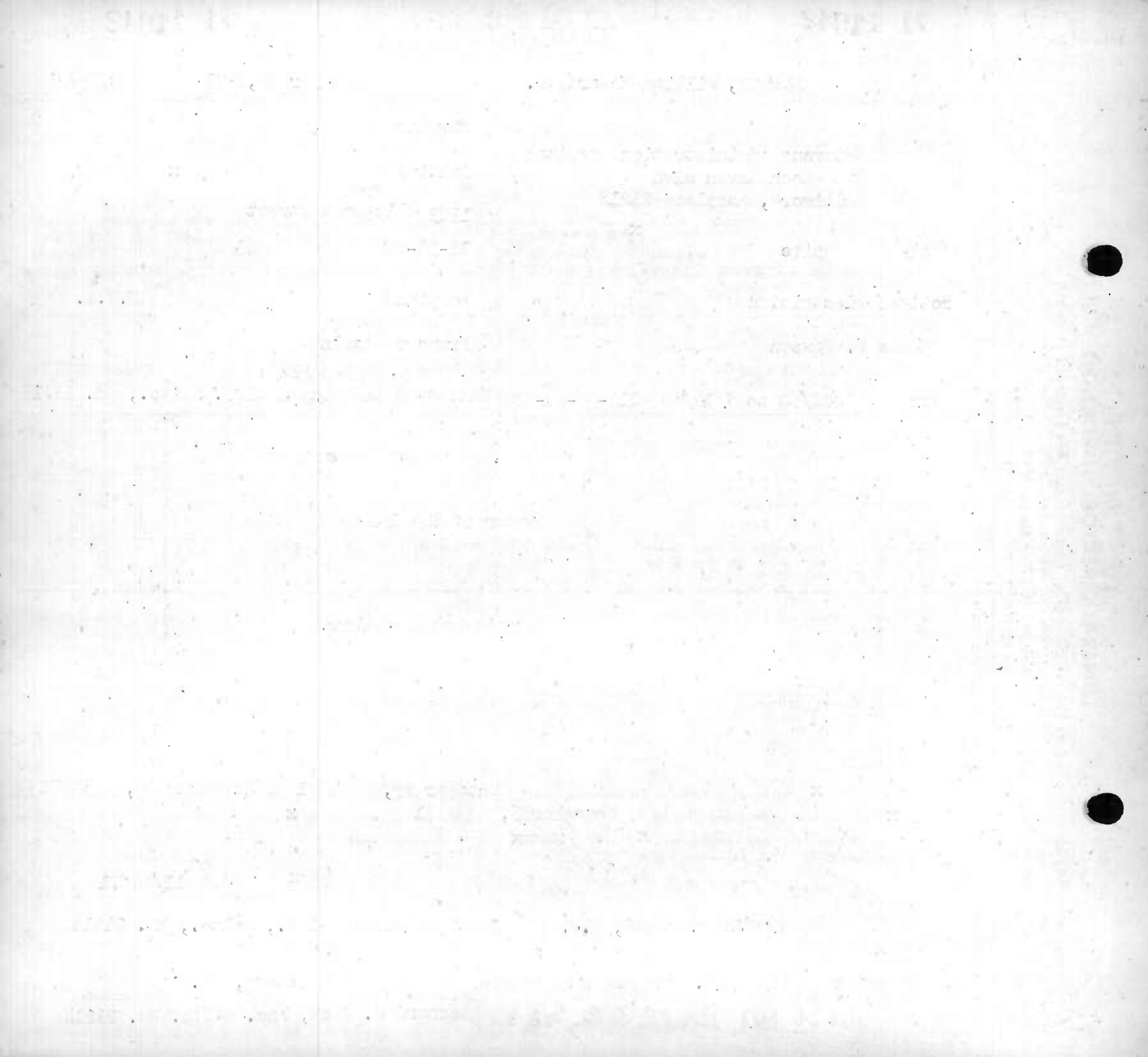
Leonard J. Ruck, Inc. Balto. Md. 21214

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 11042	
BIRTH NO. 71 11042				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DAWSON, William Howard Sr.			2. DATE AND HOUR OF DEATH November 25, 1971 3:00 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 203		
5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12-18-09 9. AGE (In years last birthday) 61 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Thomas N. Dawson		
14. MOTHER'S MAIDEN NAME Frances Staylor			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/22/50 to 9/30/50		
16. SOCIAL SECURITY NO. 212-05-82-73			17. INFORMANT Records ADDRESS VAH, 3900 Loch Raven Blvd. Balto., Md. 21218		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cancer of the lung OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic brain syndrome				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that 25 (this hospital) attended the deceased from October 29, 1971 to November 25, 1971 , that 25 (we) last saw the deceased alive on November 25, 1971 and that in 25 (our) opinion death occurred on the date and hour and from the causes stated above. 25 (We) (did) not view the body after death.			
23A. SIGNATURE KAMEEL F. FARAG M.D.				23B. DATE SIGNED 11/26/71	
23C. PHYSICIAN'S NAME (Type) KAMEEL F. FARAG, M.D.				23D. ADDRESS 3900 Loch Raven Blvd., Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11/29/71		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11043	
BIRTH NO. 71 11043				1. NAME OF DECEASED (Type or Print) CINDRIC JOSEPH		2. DATE AND HOUR OF DEATH 11/26/71 9:01 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTO. 42				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto County 5300 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2303 Ellen Ave # 21234			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/97	9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - mine worker		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - mine worker			10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Austria Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ? Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 178-07-3793		17. INFORMANT Pauline Thrasher (daughter)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 5741 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) Acute myocardial Infarction (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins.				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 19A. DATE OF OPERATION 11/9/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cholecystitis & common duct stones 20A. AUTOPSY? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If yes, notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/23/71 19 71 to 11/26 19 71 that (I) (we) last saw the deceased alive on 11/26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Reynaldo G. Meneses M.D.				23B. DATE SIGNED 11/26/71		23C. PHYSICIAN'S NAME (Type) REYNALDO G. MENESES, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/71		24C. NAME of CEMETERY or CREMATORY St Mary's		24D. LOCATION Uniontown Penna	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Md			



F435

BALTIMORE CITY HEALTH DEPARTMENT

71 11044

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11044

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANDRE C. FELDMAN

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 815 Abbott Ct.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

11

29

1971

12:35a

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 1002

6. SEX

male

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

8-9-53

10. AGE (in years
last birthday)

18

11. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

815 Abbott Ct.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Levi Feldman

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14b. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Jean Lamma

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Jean Feldman 815 Abbott Court

19.

304.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Narcotics addiction

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-29-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-2-71

24C. NAME of CEMETERY or CREMATORY

Balto. Cemetery

24D. LOCATION

(City, town, or county)

(State)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Wm C March 928 E North Ave.

DEPT. OF AGRICULTURE, BUREAU OF PLANT INDUSTRY, WASHINGTON, D. C.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 11045		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11045	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Esander Loney</u>		2. DATE AND HOUR OF DEATH <u>3:05 pm Nov 28, 1971</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> 802			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1809 N. MILTON AVE.</u>			
5. SEX <u>MALE</u>	6. RACE <u>BLACK</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/27</u>	9. AGE (In years last birthday) <u>44</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>AARON LONEY</u>		14. MOTHER'S MAIDEN NAME <u>ISABELLE ELLIOTT</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-32-9287</u>		17. INFORMANT <u>Mrs. Helen Loney</u> ADDRESS <u>1809 N. Milton Ave</u>	
18. <u>750X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>esophageal rupture</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>carcinoma of esophagus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Nov 27</u> 19 <u>71</u> to <u>Nov 28</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>Nov 28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John C. Ruckdeschel</u>		23B. DATE SIGNED <u>11/28/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>JOHN C. RUCKDESCHEL, M.D.</u>		23D. ADDRESS <u>1207 BOLTON ST. BALTIMORE 21217</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-2-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION <u>Balto., Md.</u>		24E. FUNERAL DIRECTOR <u>Wm C March</u> ADDRESS <u>928 E North Ave.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm C March</u> ADDRESS <u>928 E North Ave.</u>	

M 320

71 11046

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11046

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
		CORNELIUS MATHEWS			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year 11 27 1971		Hour 4:45 P.M.	
00 1828 N. Dallas St.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 806			
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 11-25-96	10. AGE (In years, lost birthday) 75	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 1828 N. Dallas St.		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		17. SOCIAL SECURITY NO. 213-16-5746		18. INFORMANT Mrs. Julia Curtis 1828 N. Dallas St	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) PARTIAL	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> m. Partial		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-28-71					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-1-71		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Wm C March 928 E North Ave.	
		24D. LOCATION (City, town, or county) Balto. Md.		24D. LOCATION (State) (State)	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ARLESTER LESTER DANIEL

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

3. DATE

PRONOUNCED DEAD

Month

Day

Year

Hour

9:48 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

1606

6. SEX

male

7. RACE

negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7/5/43

10. AGE (In years
lost birthday)

28

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2600 blk. Edmonson Ave.

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard LATHAM

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

148. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

BETTY DANIELS

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

CLARA DANIELS 2046 E. Preston St

19.

E-965 X

CAUSE OF DEATH

Multiple gunshot wounds of chest & abdomen

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

cab

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1300 Spring St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

11-26-71

P.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during attempted holdup of an
off duty policeman.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-27-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/2/71

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

(State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

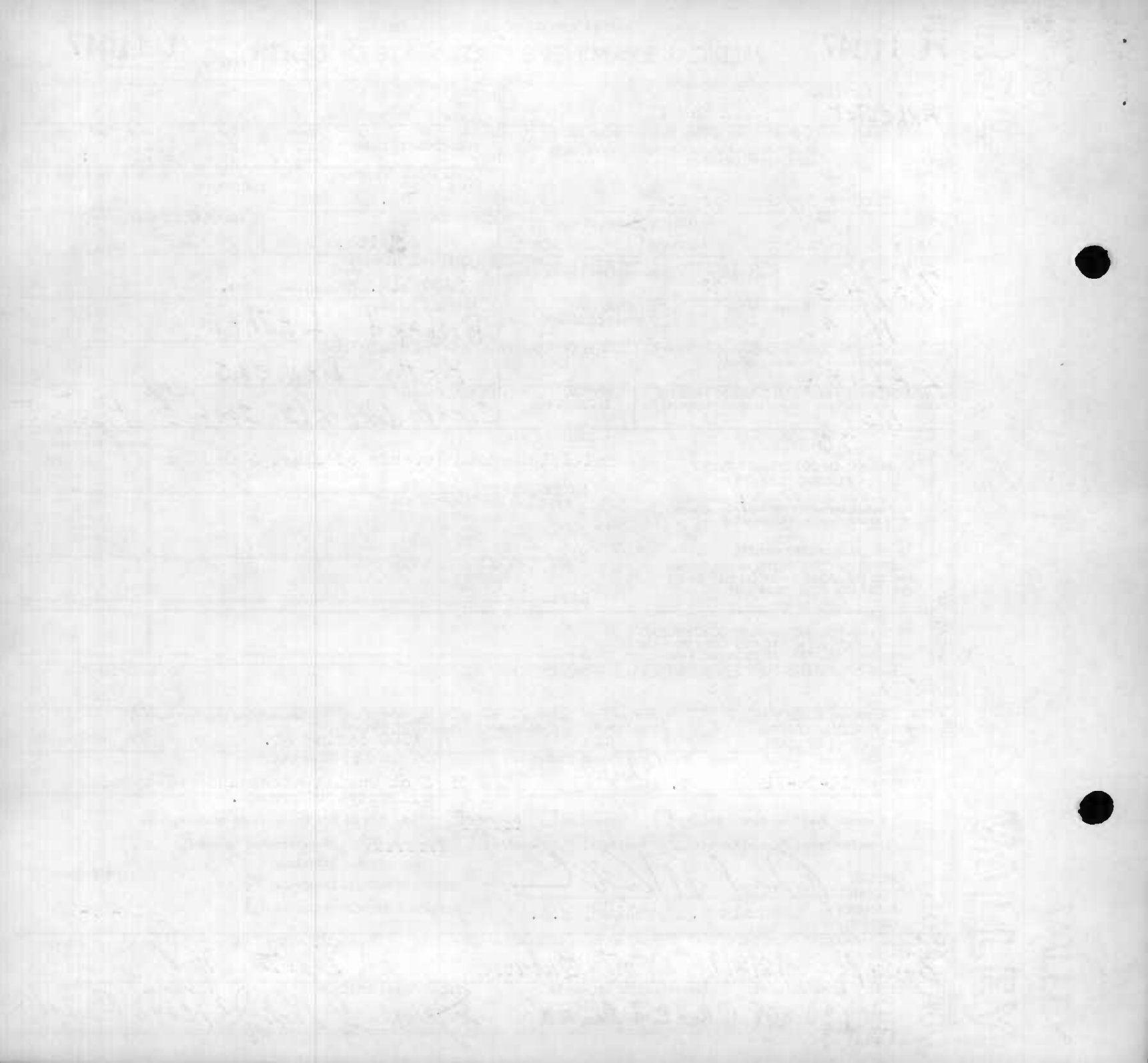
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

Joseph B. Rock, Jr. 1504 N. Central St

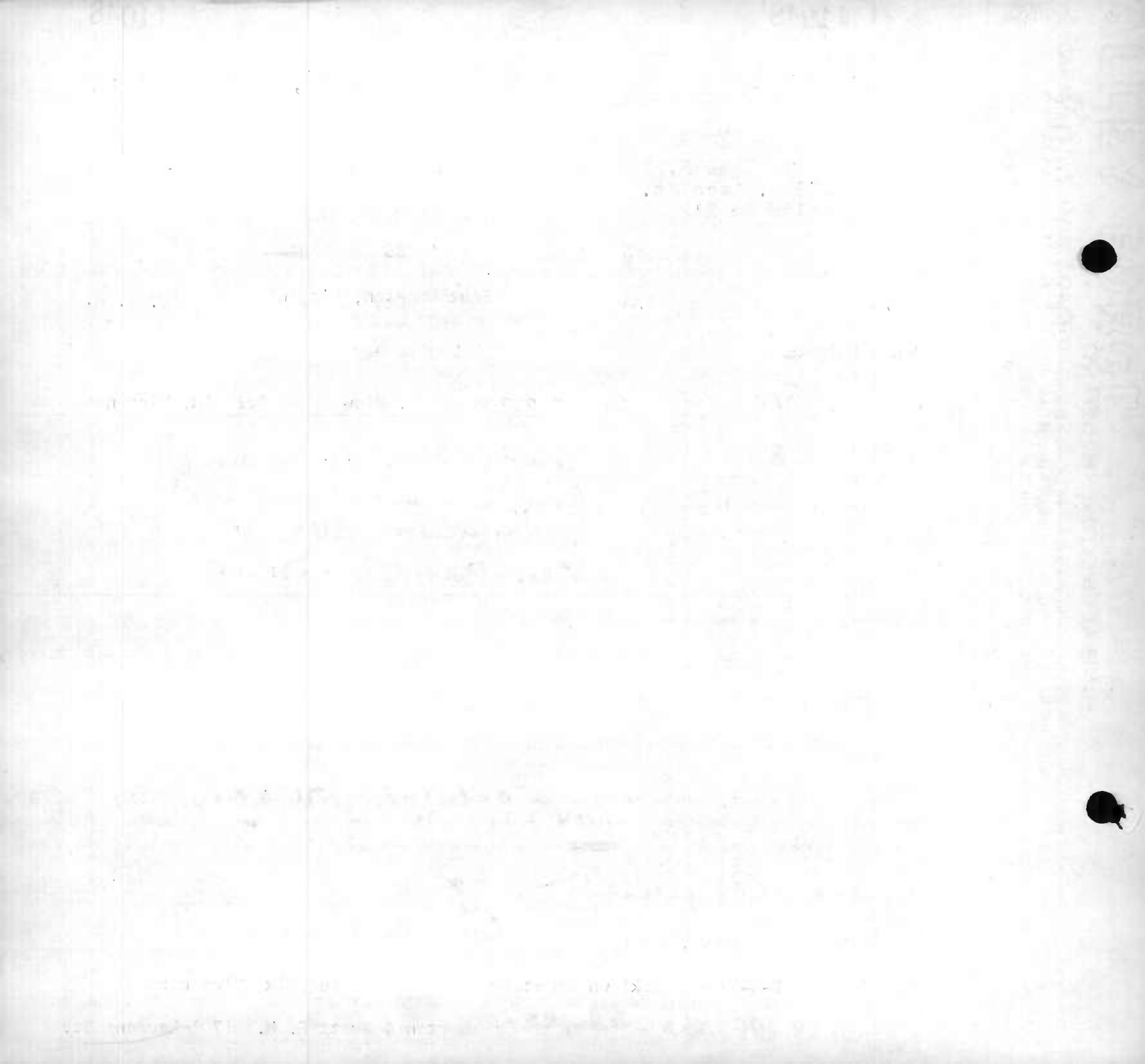
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

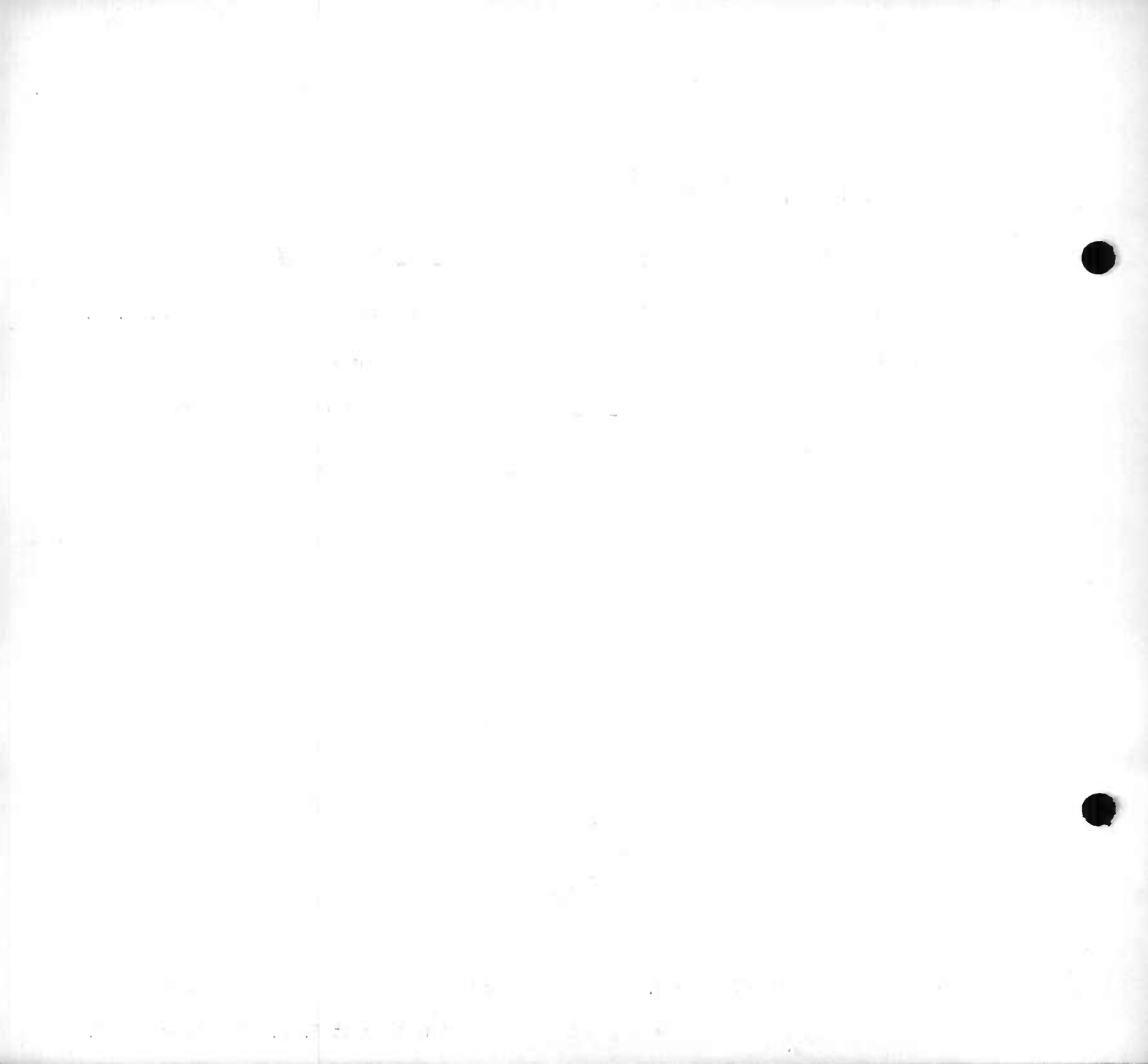
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11048
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Julia ASHBEE		2. DATE AND HOUR OF DEATH Nov 29, 1971 12:25 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 CENTURY HOME, INC 102 N. Paca St. Balto Md 21201		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1002 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1122 Webb Ct		
5. SEX F	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/88	9. AGE (In years last birthday) 82 If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Southampton, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Jonas Fulgham		
14. MOTHER'S MAIDEN NAME Louise Day		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A		
16. SOCIAL SECURITY NO. 231 40 2930A		17. INFORMANT M. Blow ADDRESS Suffolk, Virginia		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 4/24 1971 19 1971 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardio Respiratory Failure 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) None		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None		
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None		
22. I certify that (I) (this hospital) attended the deceased from Oct 14 1971 to Nov 27 1971 , that (I) (we) last saw the deceased alive on Nov 27 1971 and that in (my) (our) opinion death occurred on the date Nov 27 1971 and hour and from the causes stated above. (I) (we) (did not) view the body after death.				
23A. SIGNATURE Willard Appleford DEGREE MD				23B. DATE SIGNED Nov 30 1971
23C. PHYSICIAN'S NAME (Type) Willard Appleford		23D. ADDRESS 6615 Reisterstown Rd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-71		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery
24D. LOCATION (City, town, or county) Suffolk, Virginia		24E. STATE Virginia		
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H. ADDRESS 1701 Laurens St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11049</u>	
BIRTH NO. <u>71 11049</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>FANNIE CORPUS</u>			2. DATE AND HOUR OF DEATH <u>11-26-71</u> <u>12:50 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1303</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2510 MADISON AVE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-01-04</u>	9. AGE (In years last birth) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>Tappahanock, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			13. FATHER'S NAME <u>WILLIAM JONES</u>		
14. MOTHER'S MAIDEN NAME <u>MARY Jones</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>212-32-4362</u>		
16. SOCIAL SECURITY NO. <u>212-32-4362</u>			17. INFORMANT <u>Mamie Jamerson=</u> ADDRESS <u>1539 Mountmor Court</u>		
18. <u>410.9 1-157.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>POSS. MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CARCINOMA OF PANCREAS</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>CARCINOMA OF PANCREAS</u>					
19A. DATE OF OPERATION <u>3/11/23/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA PANCREAS</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>11/16</u> 19 <u>71</u> to <u>11/26</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>11/26</u> 19 <u>71</u> and that (in my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Leslie Pearlstein MD</u>				23B. DATE SIGNED <u>11/26/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>LESLIE PEARLSTEIN MD</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-30-71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett F. H. 1701 Laurens St.</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 11050

71 11050

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William T. Huffstutler

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Loch Raven V.A. Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

11

25

71

9:45 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

6. SEX

male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Millersville

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10/1/32

10. AGE (In years
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

Rt. #2 Box 180

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Julius Huffstutler

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Welder

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Rilla Love

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korean

17. SOCIAL
SECURITY NO.

497 30 0300

18. INFORMANT

ADDRESS

Loch Raven V.A. Hospital

Balto. Md.

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Pulmonary tuberculosis

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/26/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/30/71

24C. NAME of CEMETERY or CREMATORY

Mt. Lebanon Cemetery

24D. LOCATION (City, town, or county)

St. Louis County

(State)

Missouri

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Wm. E. Johnson

ADDRESS

Balto. Md.

1-26-1972 - Letter - Completion of cause of death on a pending medical death certificate
Peter Lipkovic, M.D.

HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 71 11051

BIRTH NO. 71 11051		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) EVANS, John Sr. (Johnnie)		2. DATE AND HOUR OF DEATH November 23, 1971 3:55A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 807 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1608 E. Oliver Street	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/14
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Construction	9. AGE (In years last birthday) 57 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses Evans		14. MOTHER'S MAIDEN NAME Bertha Langley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-9-43 to 11-17-45		16. SOCIAL SECURITY NO. 197-09-03-19	
17. INFORMANT Records Lura Evans		ADDRESS VAH 3900 Loch Raven Blvd., Balto., Md. 21218	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 1970 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Synovial Cell Sarcoma 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Respiratory Failure 2 mo DUE TO, OR AS A CONSEQUENCE OF: (B) Multiple Metastatic Lesion (Lung) 2 mo (C) Synovial Cell Sarcoma 1 yr	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from November 3, 1971 to November 23, 1971, that (X) (we) last saw the deceased alive on November 23, 1971 and that (X) (our) opinion of death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.			
23A. SIGNATURE H. L. MUNCIE, JR., M.D.		23B. DATE SIGNED 11/24/71	
23C. PHYSICIAN'S NAME (Type) H. L. MUNCIE, JR., M.D.		23D. ADDRESS 3900 Loch Raven Blvd., Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-28-71	
24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Talley, R.D.	
25C. FUNERAL DIRECTOR 1735 Harford Ave. ADDRESS Marshall W. Jones, Jr.		25D. ADDRESS	



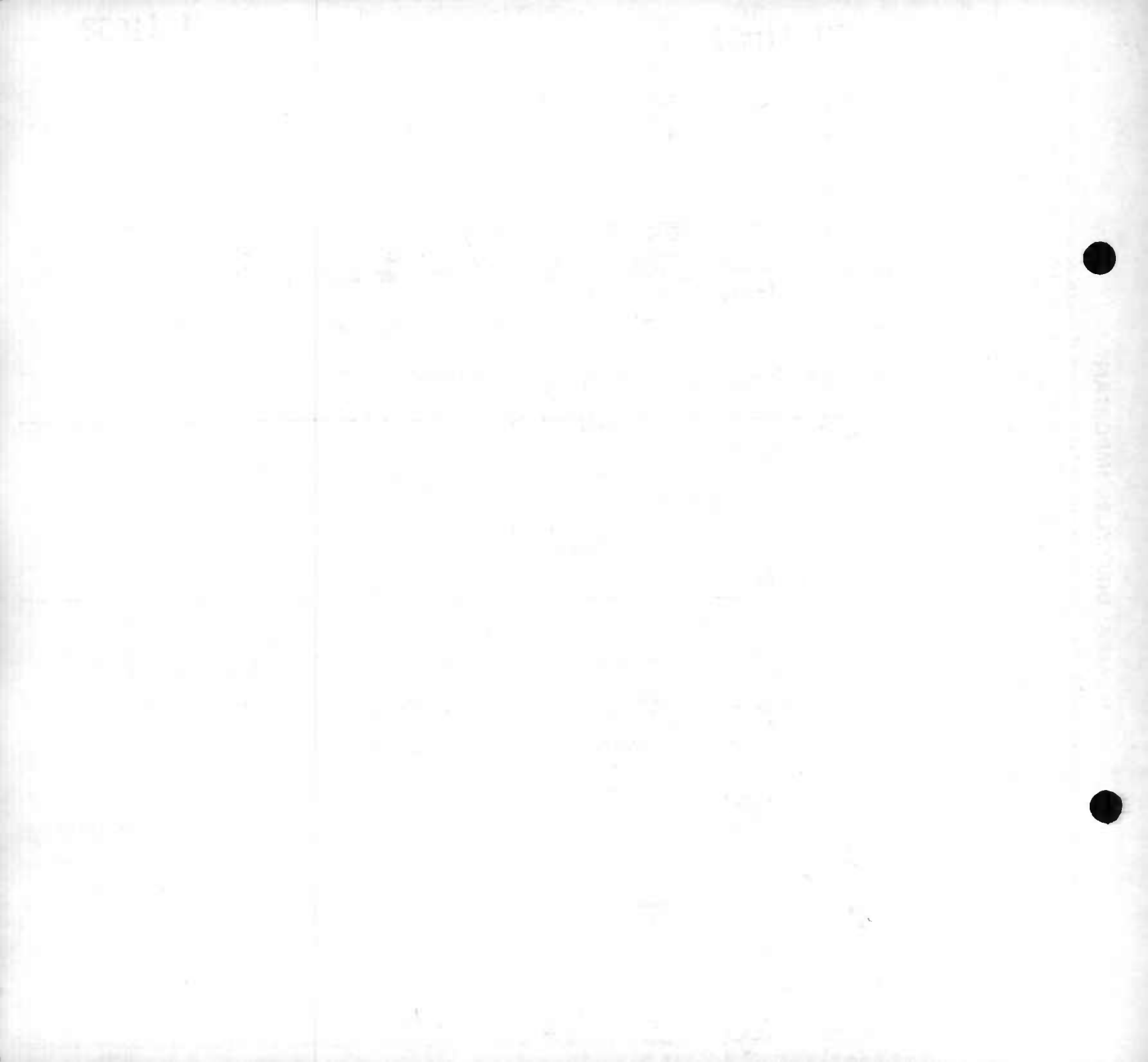
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 11052

BIRTH NO. 71 11052		1. NAME OF DECEASED (Type or Print) Louis Keith		2. DATE AND HOUR OF DEATH 11-28-71 8.00 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 44		A. STATE MARYLAND		B. COUNTY 1204	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 328 E 20TH STREET			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-8-26	9. AGE (In years last birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER		10B. KIND OF BUSINESS OR INDUSTRY Dukeland Packing Co.		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME NEWITT KEITH		14. MOTHER'S MAIDEN NAME HANERVA STUBURN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 246-42-2795		17. INFORMANT LUCILLE KEITH 328 E. 20th St. 21218	
18. 430.91 CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RESPIRATORY ARREST			
ANTECEDENT CAUSES		(B) SUBARACNOID HEMORRHAGE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-21-71 to 11-28-71 that (I) (we) last saw the deceased alive on 11-28-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juan M. Calderon M.D.		23B. DATE SIGNED 11-28-71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON M.D.		23D. ADDRESS UMH-			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-2-1971		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR 1735 Harford Ave. ADDRESS Marshall W. Jones, Jr.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT C MARSHALL				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 24, 1971	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital				3. DATE PRONOUNCED DEAD Month Day Year November 24, 1971 6:40 P M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1505					
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2-29-1931		10. AGE (In years last birthday) 40	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME E. Bernard Marshall		E. STREET AND NUMBER 3210 Leighton Ave.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Councilman		15. MOTHER'S MAIDEN NAME Anna Addison		16. KIND OF BUSINESS OR INDUSTRY	
17. SOCIAL SECURITY NO. 217-24-2508		18. INFORMANT Mrs. Alice Marshall		ADDRESS 21215 3210 Leighton Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No) Yes	
26. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-25-71	
32. BURIAL CREMATION, REMOVAL (Specify) Burial		33. DATE 11-29-71		34. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	
35. DATE REC'D BY HEALTH DEPT. NOV 30 1971		36. NAME OF REGISTRAR Robert E. Jackson, M.D.		37. FUNERAL DIRECTOR 1735 Harford Ave. Marshall W. Jones, Jr.	

11 11 11

11 11 11



11 11 11

CERTIFICATE OF DEATH

BIRTH NO. 71 11054

1. NAME OF DECEASED
(Type or Print)

Robert W. Cosgrove, SR.

2. DATE AND HOUR OF DEATH

11/27/71

9 25A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

422 South Oldham Street 21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7-12-06

9. AGE (in years lost birthday)

65

10. Under 1 Yr.

Months: Days:

11. Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

Maryland, Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert R. Cosgrove

14. MOTHER'S MAIDEN NAME

Mary Schneiser

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-07-2257A

17. INFORMANT

4940 Eastern Avenue

BCH: Records Baltimore, Maryland 21224

18. 430.01471X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

B UGI Bleed

C A-V malformation, Hypertension

DUE TO, OR AS A CONSEQUENCE OF:

E Pneumonia

F postnecrotic cirrhosis

G Porta caval shunt

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

3 11/24/71

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Tracheostomy - respiratory

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

(APPROX.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 11/18/71 to 11/27/71 that (1) (we) lost saw the deceased alive on 11/27/71 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Karen O'Neill

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

11/27/71

23C. PHYSICIAN'S NAME (Type)

K Karen O'Neill

DEGREE

23D. ADDRESS

4940 Eastern Avenue Balto. Md. 21224

Baltimore City Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-1-71

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart Cemetery

24D. LOCATION

(City, town, or county)

(State)

7401 German Hill Rd., Ba. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, MD.

25C. FUNERAL DIRECTOR

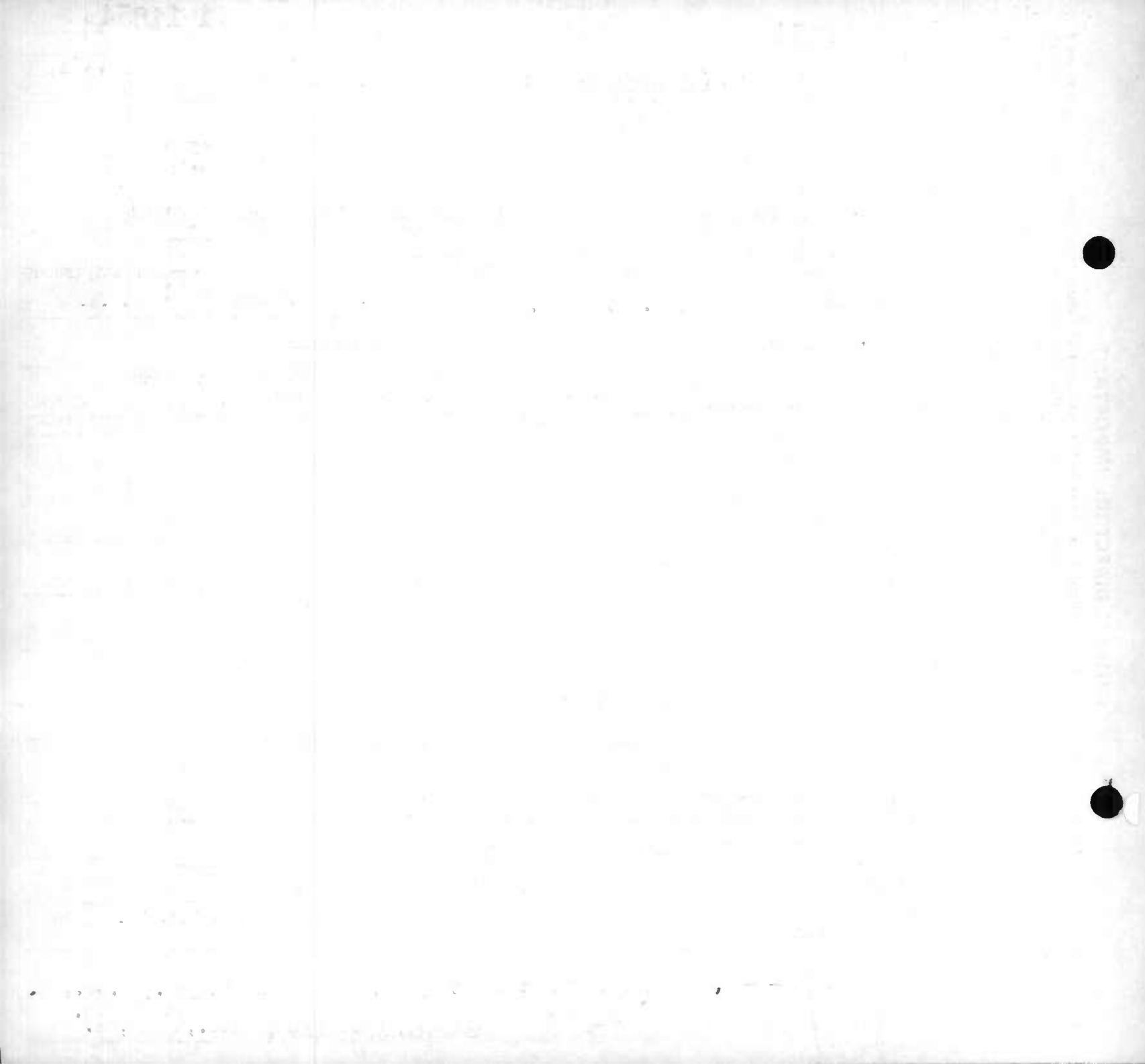
Charles J. Geiler

ADDRESS

6224 Eastern Ave. Balto., 21224, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



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T520

71 11055

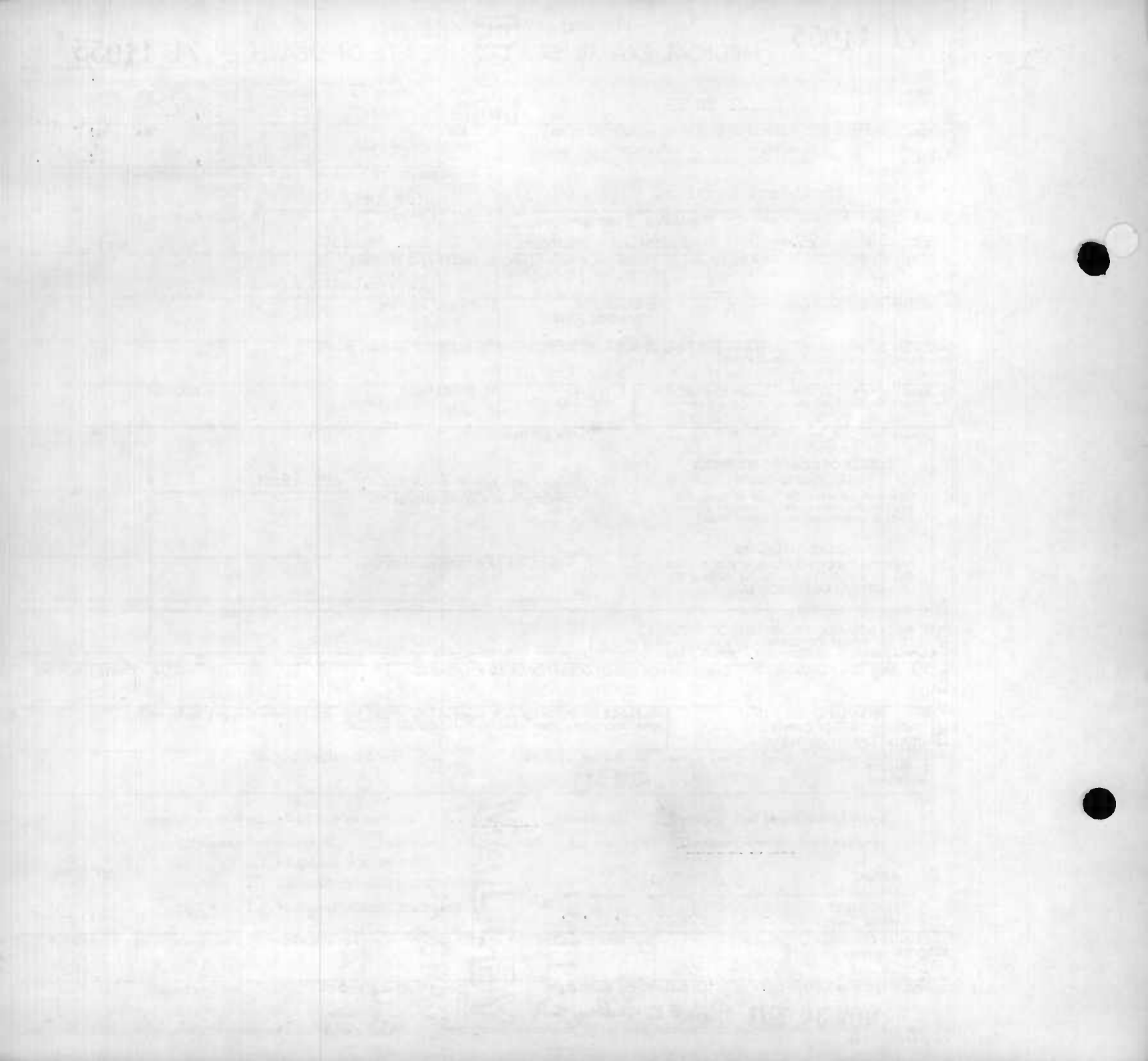
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11055

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BETTY TOWNS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year November 20, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 20, 1971 9:56 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1401	
9. DATE OF BIRTH 6/15/38		10. AGE (In years last birthday) 33	
11. BIRTHPLACE (State or foreign country) Baltimore, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 450X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 21, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/71	
24C. NAME OF CEMETERY or CREMATORY MT Calvary Cem		24D. LOCATION (City, town, or county) (State) H.A. County, MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Sam F. Carroll		ADDRESS 1212 W. W. W.	



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71 11056

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11056

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margarette Lyons		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 16 71 11:55 a.m.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1002	
6. SEX female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9/6/1925		10. AGE (in years last birthday) 46		E. STREET AND NUMBER 918 N. Central Avenue	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 4319 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Intracerebral hemorrhage		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/17/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/20/71		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Co.	
24D. LOCATION (City, town, or county) (State) A.A. County, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Sam F. Carroll		25D. ADDRESS 1212 W. North			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPT.		REG. NO.	
1. NAME OF DECEASED (Type or Print) WALTER D. McCLURE		2. DATE AND HOUR OF DEATH Nov. 24, 1971 12:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ADDRESS OR LOCATION 4940 Eastern Avenue, Baltimore, Md.		E. STREET AND NUMBER 101 Back RIVER NECK Rd. 21221			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/06	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer - cement piter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 231-12-9355A		17. INFORMANT Naomi Parks 101 Back River Neck	
18. 162,111		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: carcinoma of lung & extensive metastases			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). pancreatitis, renal failure, hypertension, tumor					
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 19 19 71 to Nov 24 19 71 that (I) (we) last saw the deceased alive on Nov 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W. Kirk M.D.		23B. DATE SIGNED 11/24/71			
23C. PHYSICIAN'S NAME (Type) JOHN W. KIRK, M.D.		23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-27-71	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	24D. LOCATION (City, town, or county) (State) Balto., Md.		
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR W. E. Taylor, R.D.	25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun St.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11058</u>
BIRTH NO. <u>71-11058</u>		1. NAME OF DECEASED (Type or Print) <u>Mr. Robert Turner</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>11-28-71</u> <u>820</u> P.M.		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bow Secours Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>County</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <u>7901 Audubon Court</u>				
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-99</u>	9. AGE (in years last birthday) <u>72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bluefield Caterers</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-01-1256</u>		17. INFORMANT <u>Vernon Turner</u> ADDRESS <u>PATIENT'S CHART SAME</u>
18. <u>250191</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Pyelonephritis</u> (B) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: <u>General Arteriosclerosis</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>15 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>none</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>11-26</u> 19 <u>71</u> to <u>11-28</u> 19 <u>71</u> that <u>he</u> (we) last saw the deceased alive on <u>11-28</u> 19 <u>71</u> and that <u>in my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Chuen T. Wong</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-28-71</u>
23C. PHYSICIAN'S NAME (Type) <u>CHUEN T. WONG</u>		23D. ADDRESS <u>Bow Secours Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12-2-71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun St.</u>



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ALEXANDER

BOONE

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

5005 Ready Ave.

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. DATE OF BIRTH

12/25/1905

10. AGE (In years
lost birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Anna

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES W.W.II

17. SOCIAL
SECURITY NO.

18. INFORMANT

Emma Chisley

ADDRESS

1844 W. Saratoga St.

19.

412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-25-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/29/71

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county)

Brooklyn, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Charles A. Rice

ADDRESS

661 W. Borne St.

10/10/1911

10/10/1911

10/10/1911

10/10/1911

10/10/1911

10/10/1911

10/10/1911

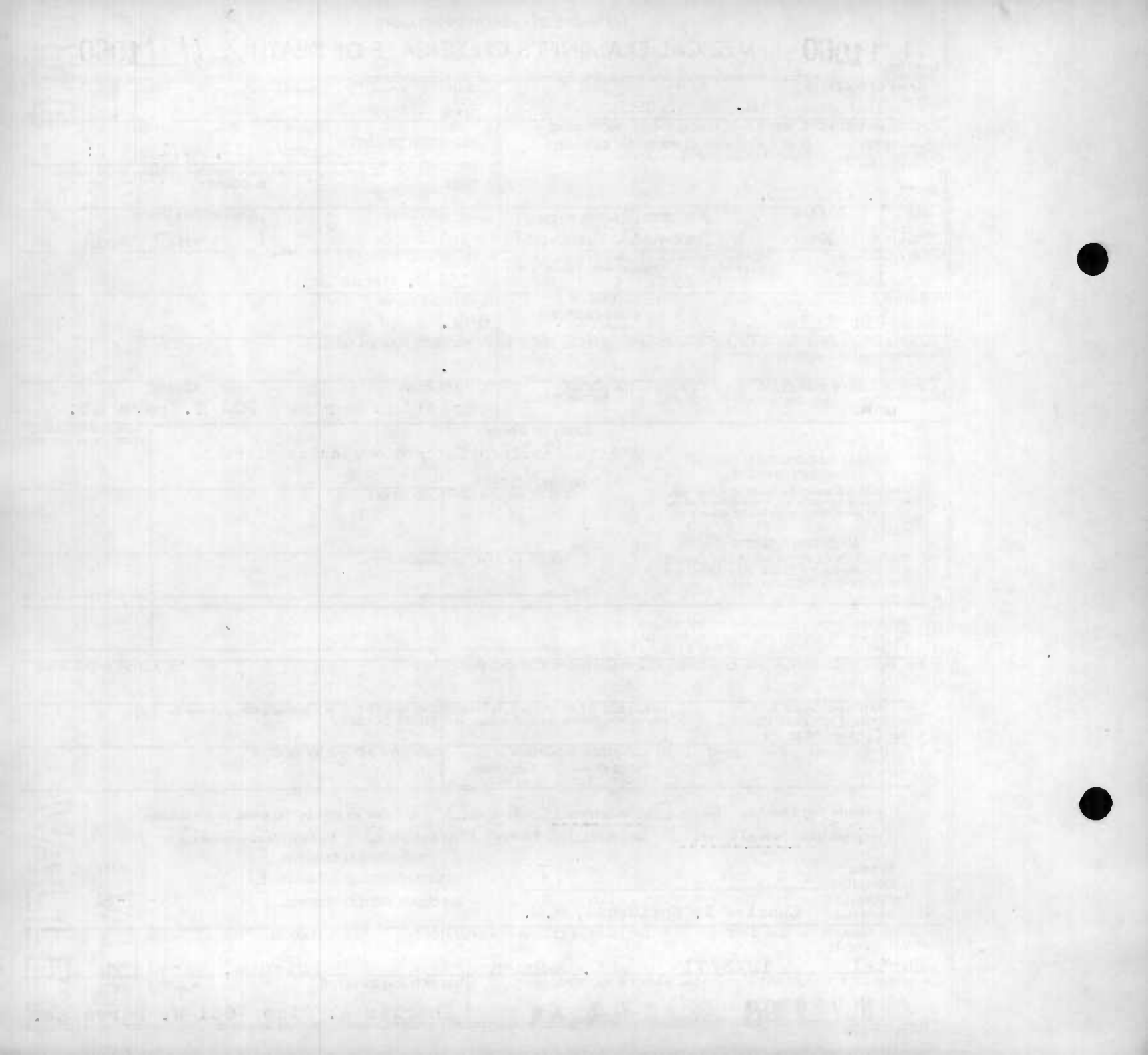
10/10/1911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JAMES E. LAWRENCE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 155 W. Cross St.		3. DATE PRONOUNCED DEAD Month Day Year Hour November 24, 1971 3:15 P M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2301			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 1902	10. AGE (In years last birthday) 69	E. STREET AND NUMBER 155 W. Cross St.	
11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME unk.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME unk.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unk.	17. SOCIAL SECURITY NO.	18. INFORMANT Christine Mercer ADDRESS 920 S. Paca St.	
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> 11-25-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/3/71	24C. NAME of CEMETERY or CREMATORY Mt. Auburn	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.	



FUNERAL DIRECTOR: IMPORTANT

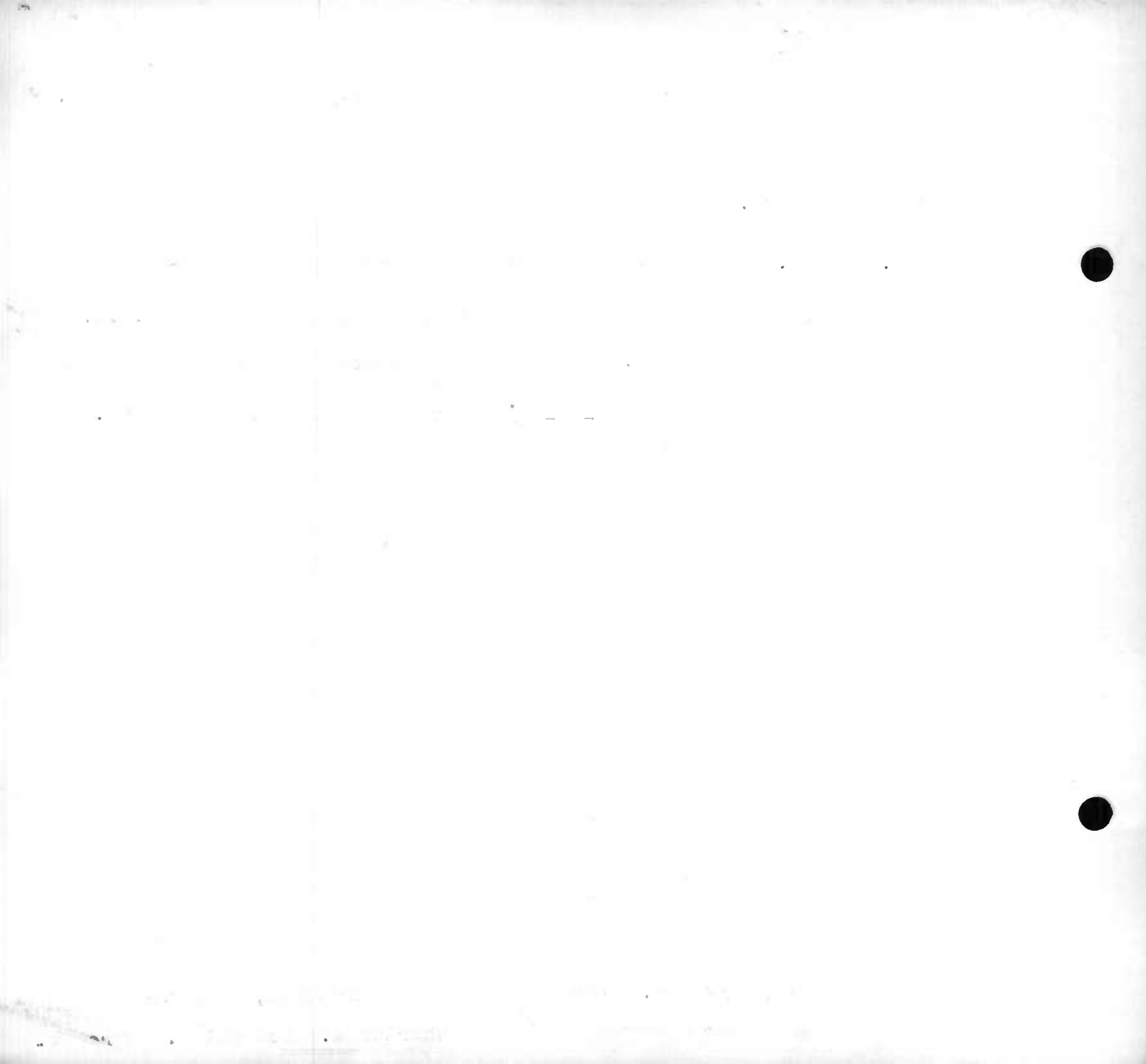
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11061

BIRTH NO. 71 11061

1. NAME OF DECEASED (Type or Print) LILLIAN H. FORBES		2. DATE AND HOUR OF DEATH 11/25/71 7:45 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2619 Cecil Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 907 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2619 Cecil Ave	
5. SEX F.	6. RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (9/11/94
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK.		14. MOTHER'S MAIDEN NAME Charlotte Harrison	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. A. 239-16-9135	
17. INFORMANT Charlotte Hill		ADDRESS 2619 Cecil Ave.	
18. 170.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Recurrent melanoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Malignant melanoma of nasal turbinate 2 1/2 yrs			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 7-28-69 1-13-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED malignant melanoma	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Kwan H. Won, M.D.		23B. DATE SIGNED 11/27/71	
23C. PHYSICIAN'S NAME (Type) KWAN H. WON, M.D.		23D. ADDRESS GBMC, Towson, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/71	
24C. NAME of CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Brooklyn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	



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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Walter Alexander Harrison		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 921 Denver Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 25 71 8:00 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2101	
9. DATE OF BIRTH 4/22/1919		10. AGE (In years lost birthday) 53	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME UNK.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		17. SOCIAL SECURITY NO. 212-18-4200	
18. INFORMANT Arlene Harrison		ADDRESS 664 Melvin Dr.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/26/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/71	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

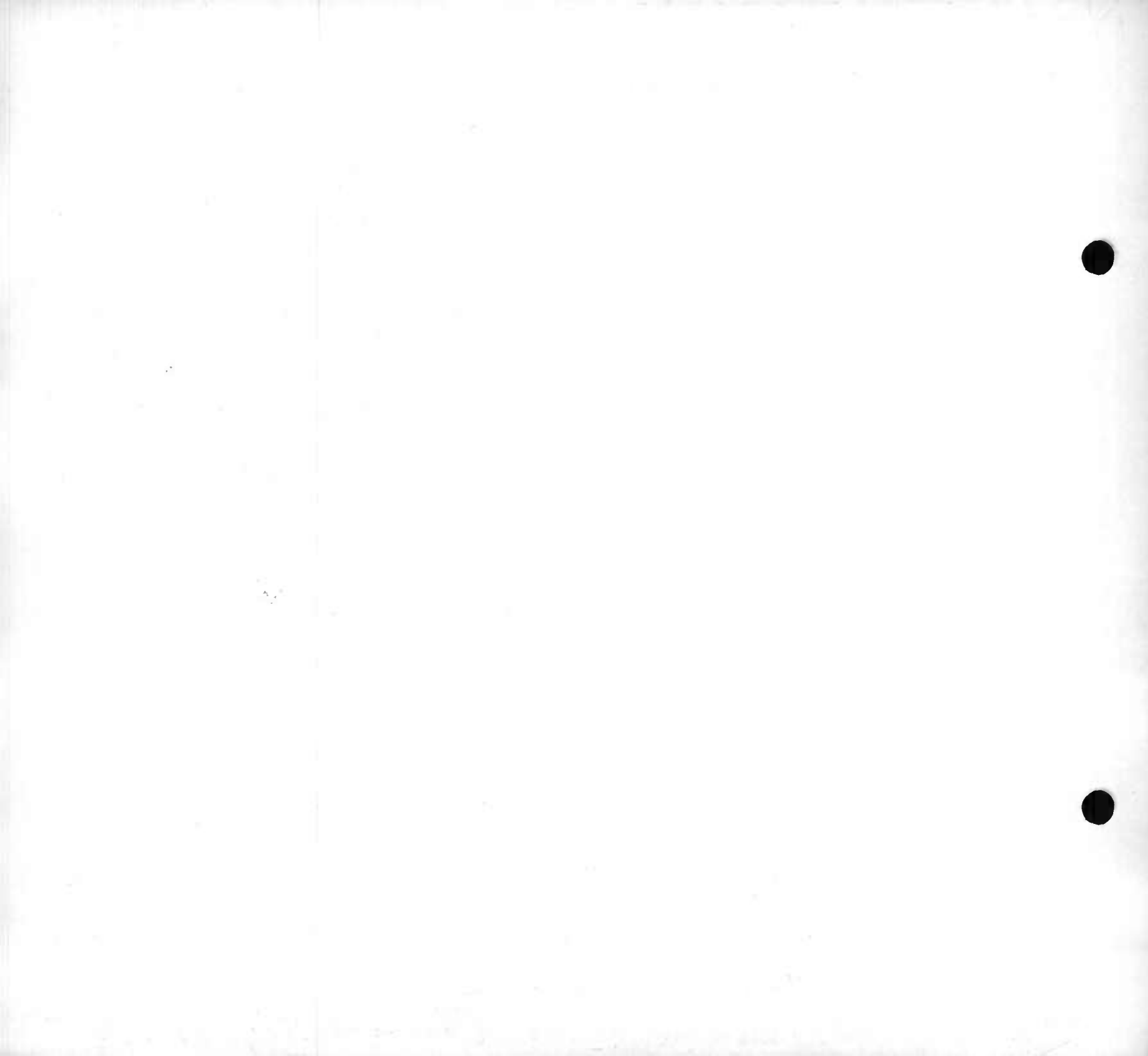
San Francisco

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11063	
BIRTH NO. 71 11063				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) NIXON REBECCA		2. DATE AND HOUR OF DEATH 11/26/71 8 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		A. STATE MO.		B. COUNTY BALTO.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2599 PARK HEIGHTS TERR.					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/1911	9. AGE (in years last birthday) 89	10. Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unk.			
14. MOTHER'S MAIDEN NAME unk.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Harvey Albritton 2208 19th St.		ADDRESS Phila. PA.			
18. 427.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE CEREBRAL VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: (B) atrial fibrillation DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/15/71 11/15/71	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/15 19 71 to 11/26 19 71 that (I) (we) last saw the deceased alive on 11/24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 11/26/71		23C. PHYSICIAN'S NAME (Type) DAVID GLASER, M.D.	
23D. ADDRESS SINAI HOSP. OF BALTO.		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/1/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Md.		24E. CITY, TOWN, OR COUNTY		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles Alice 6614 Barre	
25D. ADDRESS					



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BALTIMORE CITY HEALTH DEPARTMENT

11 11064		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		11 11064	
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH			
WILLIAM SCOTT		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD			
00 662 Portland St.		Month Day Year Hour 11 27 1971 4:22 a M.			
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
male		negro		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH		10. AGE (In years lost birthday)		D. INSIDE CITY LIMITS?	
11/24/92		79		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER	
Virginia		U.S.A.		662 Portland St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME	
Retired		Construction		George Scott	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME	
No		216-10-8134		Mildred Scott	
19. CAUSE OF DEATH		18. INFORMANT		ADDRESS	
412-301-1517		Alice Mitchell		929 N. Washington St.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Hypertensive cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Carcinoma of stomach			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
0				NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23.					
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		11-27-71	
Ronald N. Kornblum, M.D.		ASSOCIATE MEDICAL EXAMINER			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/1/71		Arbutus Memorial Pk.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 30 1971		Robert E. Farber, M.D.		Charles A. Rice	
				661 W. Barre St.	

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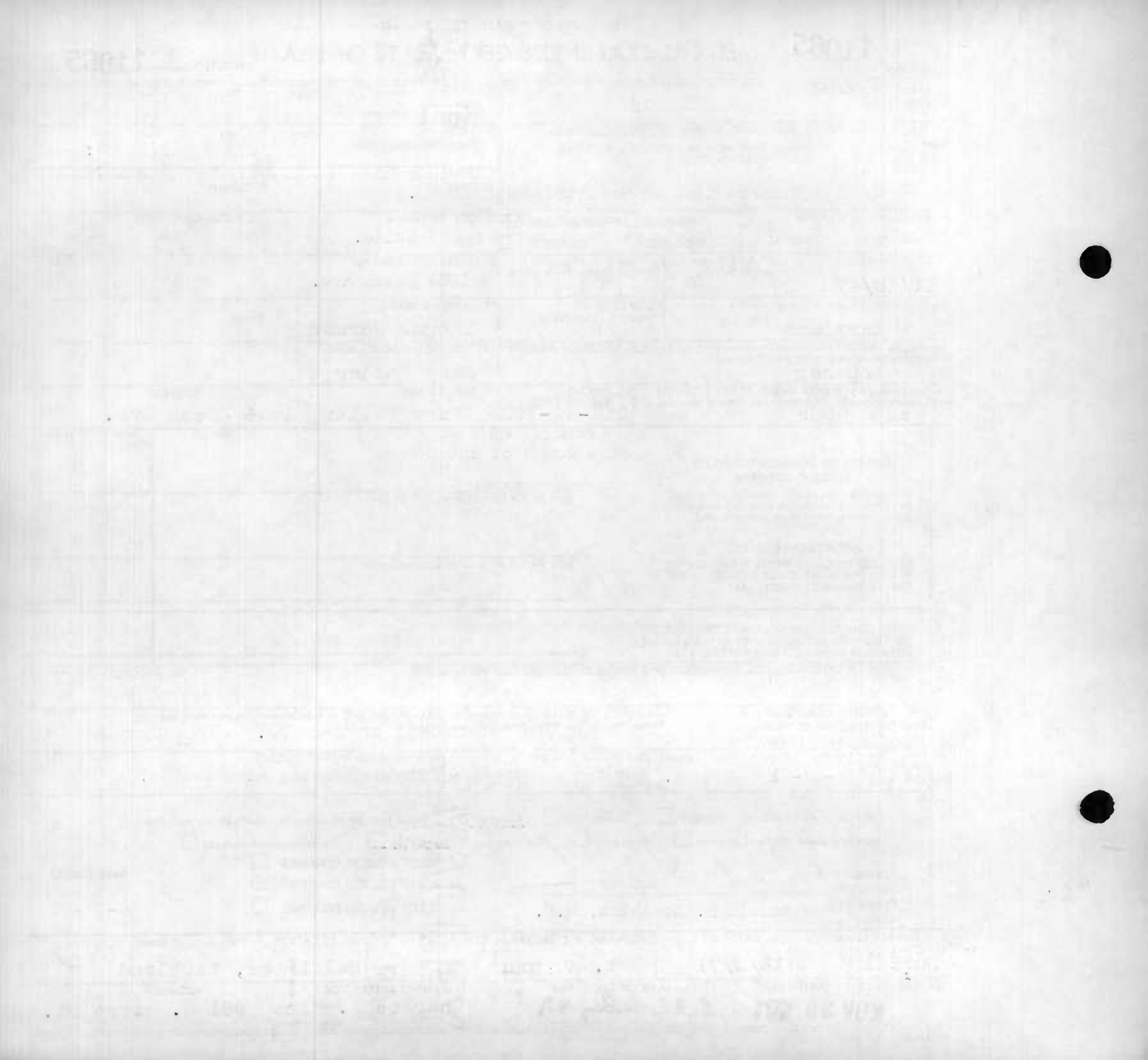


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO. 11065

1. NAME OF DECEASED (Type or Print) THOMAS GERMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 28 1971 2:45 a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2301	
9. DATE OF BIRTH 11/10/47		10. AGE (In years last birthday) 24 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		13. FATHER'S NAME Thomas German	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes unk		15. MOTHER'S MAIDEN NAME Mary Fetler	
17. SOCIAL SECURITY NO. 213-32-1923		18. INFORMANT Mary Fetler	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E966 IX Stab wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22D. TIME OF INJURY (APPROX.) 11-28-71 a.m.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2805 Spellman Rd. 2562	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-28-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/2/71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

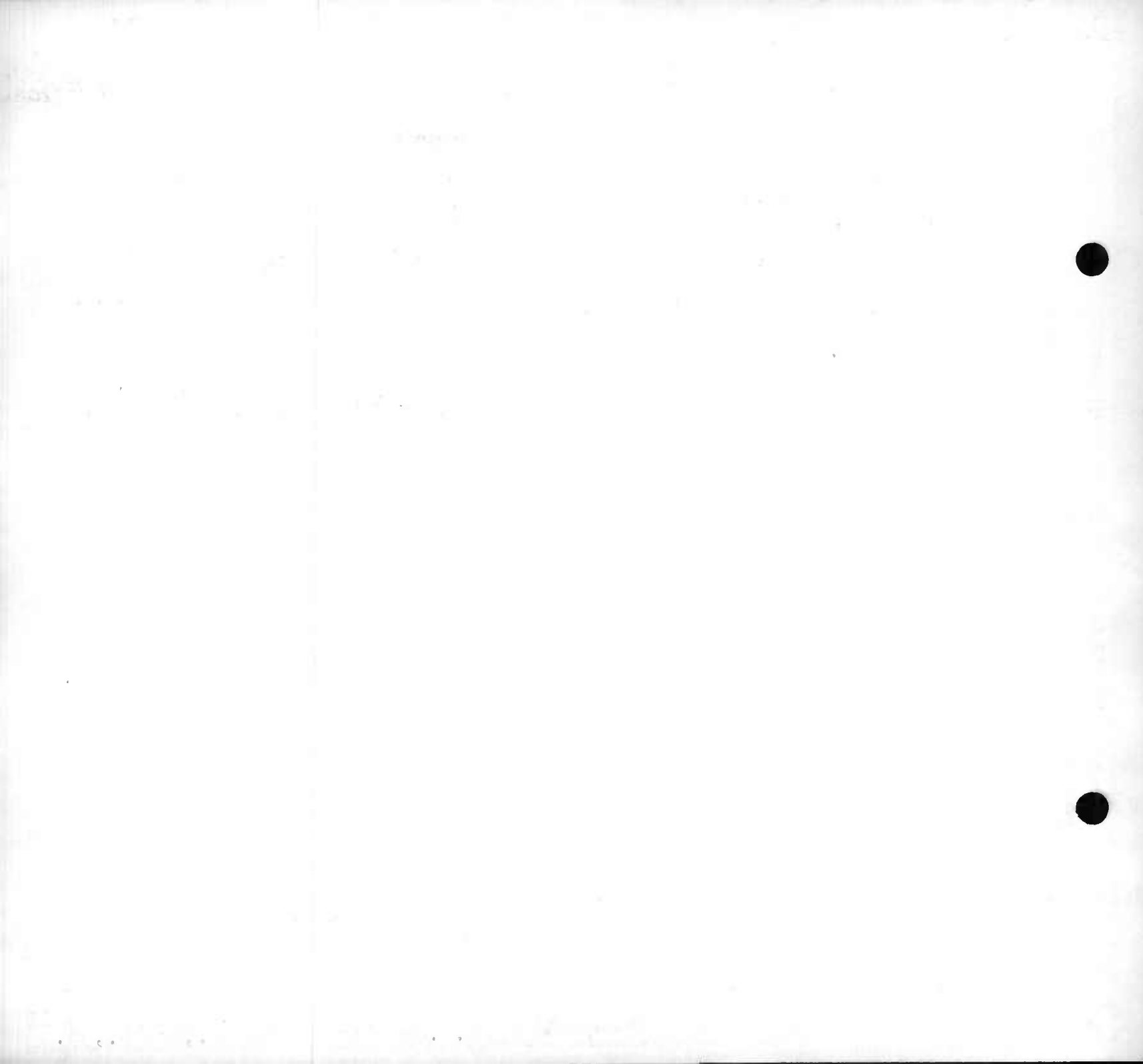
B 4601		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11066	
71 11066		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MAVIN BOULWARE		11/29/71		2:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
BON SECOURS HOSPITAL 34		MARYLAND		2004	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		138 Willard Street		21223	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/9/53	18	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Male Nurse				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John H. Boulware		Bernice Brown		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		320-64-3784		Bernice Boulware 138 S. Willard St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Hepatic coma	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Hemolytic crisis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Sickle cell anemia		7 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
None				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				Yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 11-18-71 to 11-29-71 that (we) lost saw the deceased alive on 11-29-71 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Charles T. Wadg		11-29-71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CHARLES T. WADG		Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-3-71		Mt. Auburn	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Baltimore, Maryland		Charles A. Rice		661 W. Barre St.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 30 1971		Robert E. Fisher, Jr.		Charles A. Rice	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 11067	
BIRTH NO. 71 11067		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Winger, Carol Killmon</u>				2. DATE AND HOUR OF DEATH <u>11-27-71</u> <u>3:40</u> am.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Virginia</u> B. COUNTY <u>V43</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				C. CITY OR TOWN <u>Norfolk</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12-19-46</u>		9. AGE (In years last birthday) <u>24</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Carl R. Killmon</u>				14. MOTHER'S MAIDEN NAME <u>Blanche</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH: RECORDS Baltimore, Maryland 21224</u>	
18. <u>207.01</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>acute leukemia</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROX.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>11-6-71</u> 19 <u>71</u> to <u>11-27</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>11-26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Larry Kvols, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-27-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>LARRY KVOLS</u>				23D. ADDRESS <u>4940 Eastern Avenue</u> <u>Baltimore City Hospital, Balto., Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>11-27-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Interred 11/29/71</u> <u>Forest Lawn</u>		24D. LOCATION (City, town, or county) (State) <u>Norfolk</u> <u>Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co., Balto., Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11068	
BIRTH NO. 71 11068					
1. NAME OF DECEASED (Type or Print) EDWARD L. LITZ		2. DATE AND HOUR OF DEATH 11/28/71 1 430 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2101			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL 38		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1143 Scott St.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09/01/60	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Trucking Co.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph Litz		14. MOTHER'S MAIDEN NAME Catherine Walts			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 05 6A1A		17. INFORMANT Wm. Alice A. Litz	
18. 303.21		ADDRESS above			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: stroke		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF:		10 years	
		(C) chronic alcoholism		50 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 28 1971 to 19 that (I) (we) last saw the deceased alive on November 28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Wexler		DEGREE IRA WEXLER		23B. DATE SIGNED Nov. 28/1971	
23C. PHYSICIAN'S NAME (Type) IRA WEXLER		23D. ADDRESS UNIV. OF MD. HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/1/71		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem.	
24D. LOCATION Howard Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. Cowan, Sr.	
				ADDRESS 9811 Belting St. Md.	



CERTIFICATE OF DEATH

REG. NO. 71 11069BIRTH NO. 71 110691. NAME OF DECEASED
(Type or Print)

STEFANOWICZ, STANLEY S. (STANISLAW)

2. DATE AND HOUR OF DEATH

November 25, 1971

8:55 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2505 Foster Avenue 21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6/10/12

9. AGE (In years
last birthday)

59 Yrs.

If Under 1 Yr.
Months

Days

If Under 24 Hrs.
Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ESTIMATOR

10B. KIND OF BUSINESS OR INDUSTRY

WHITING-TURNER

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John

14. MOTHER'S MAIDEN NAME

Aniella PIEKARSKA

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

217-03-7419

17. INFORMANT

4940 Eastern Avenue ADDRESS
BCH-Records Baltimore, Maryland 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia, LL

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Adenocarcinoma, metastatic to bone
prob. pancreatic

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or above
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/14 19 71 to 11/25 19 71
that (I) (we) last saw the deceased alive on 11/25 19 71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) ☒ (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

Dr. R. Hill, MD

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11/25/71

23D. ADDRESS

4940 Eastern Avenue Baltimore, Md 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

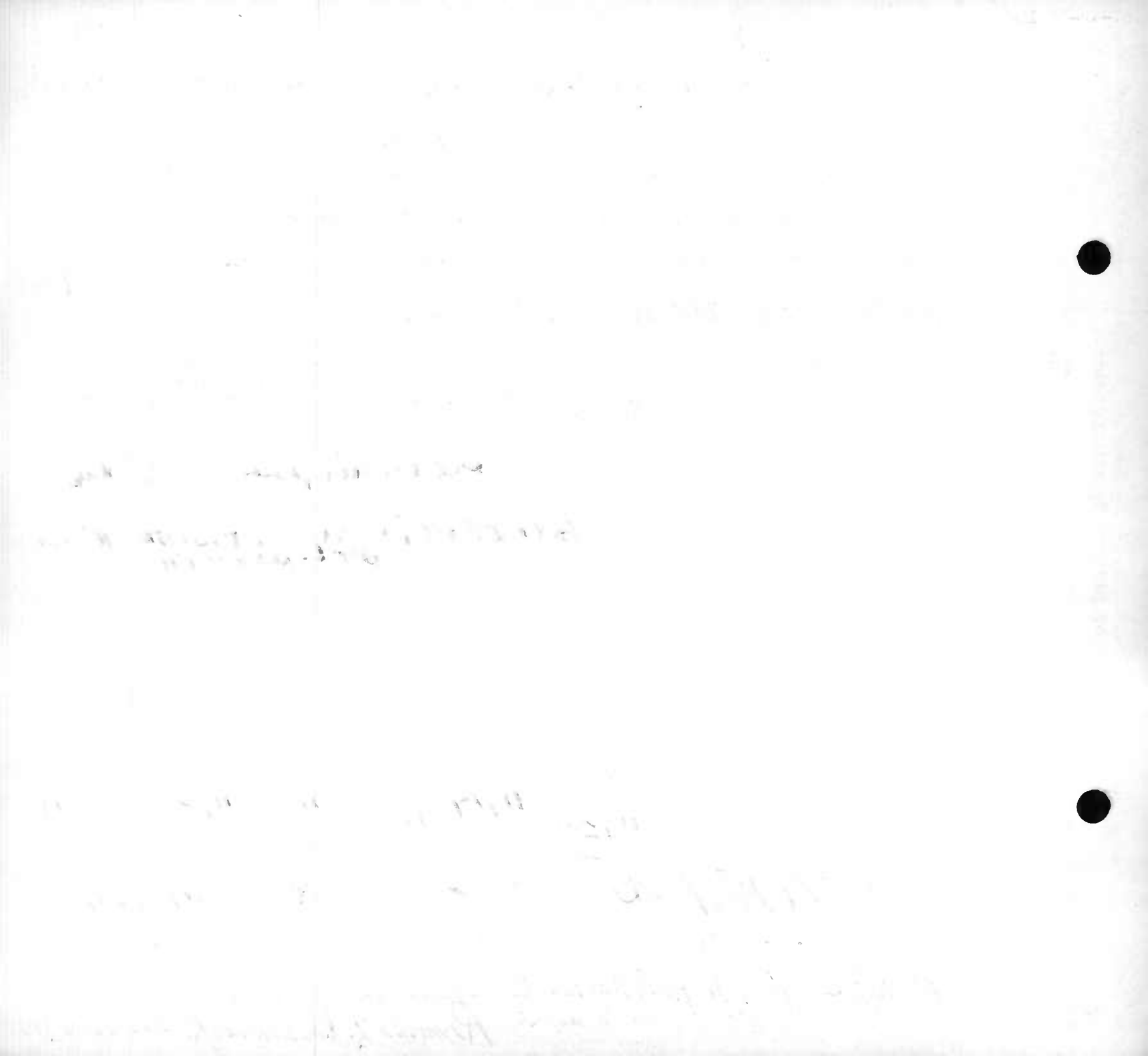
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

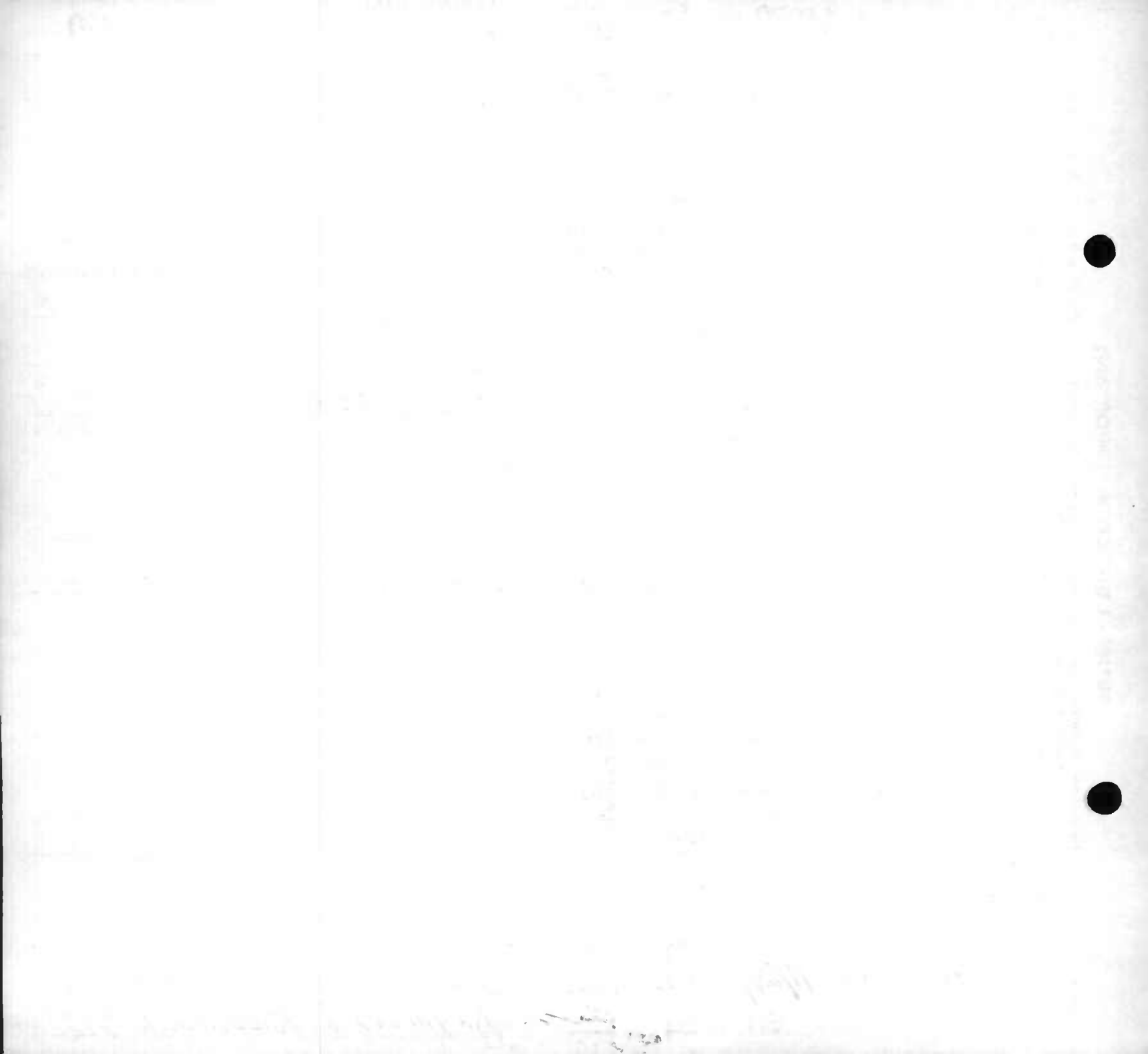
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

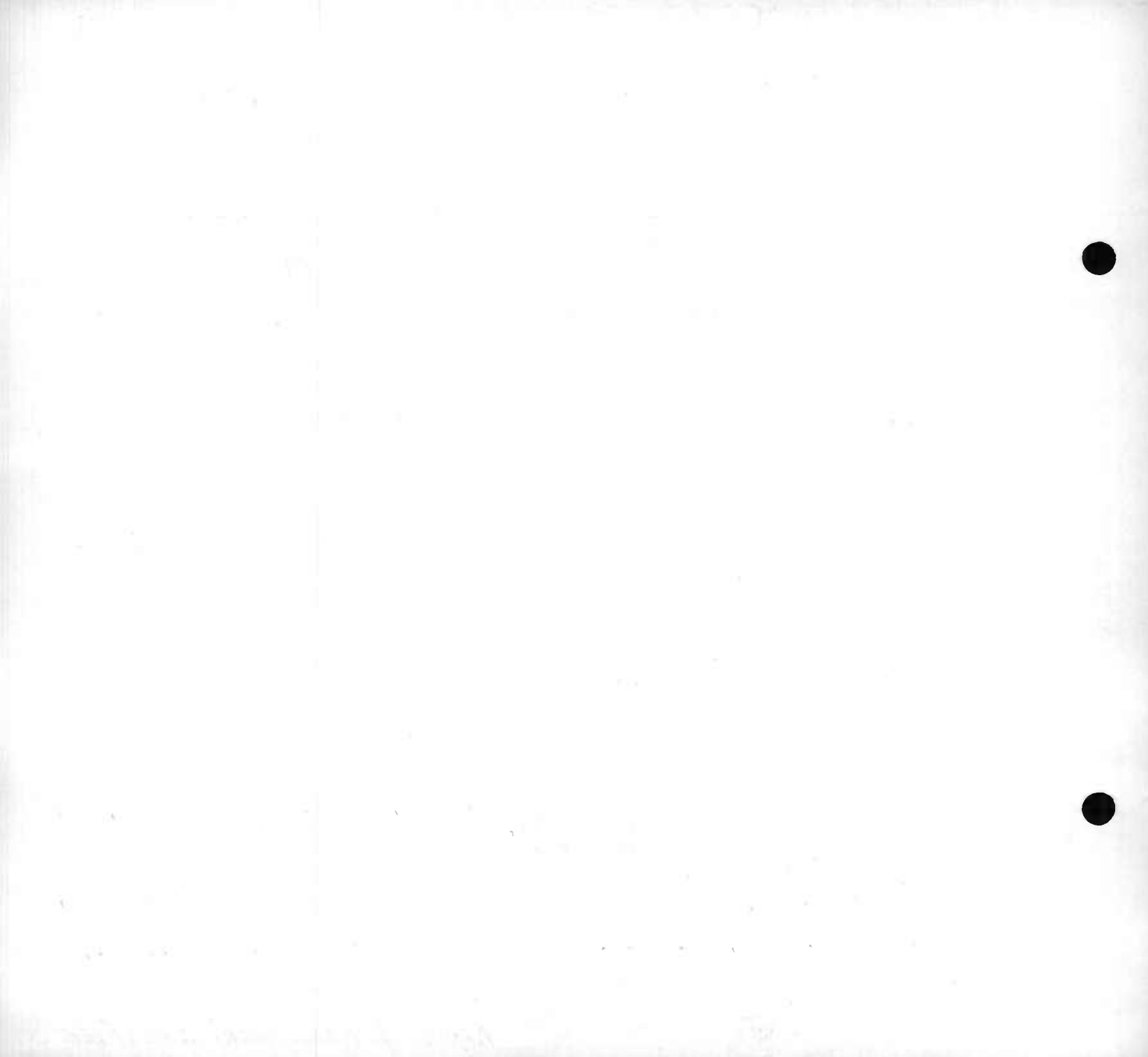
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>11070</u>	
BIRTH NO. <u>71 11070</u>		1. NAME OF DECEASED (Type or Print) <u>JENNIE G. KULISIEWICZ</u>		2. DATE AND HOUR OF DEATH <u>11-25-1971 at 4:25 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>USD</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME & HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 100 N. Broadway, Baltimore, MD</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>Fleet Street, 2541</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06-27-1905</u>	9. AGE (in years last birthday) <u>66 yrs.</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>		
13. FATHER'S NAME <u>Anthony Trentowski</u>			14. MOTHER'S MAIDEN NAME <u>Frances Dregka</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>213 10 3464</u>		17. INFORMANT <u>MRS. W. HRYNCZYKSYN</u>		
			ADDRESS <u>2541 FLEET ST</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive heart failure</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Subphrenic abscess, Diverticulitis</u>							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>15th Nov 1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Subphrenic abscess, Diverticulitis</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10-15-1971</u> to <u>11-25-1971</u> that (I) (we) last saw the deceased alive on <u>11-25-1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>T. Sree Ramamurthy</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-25-1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>T. SREE RAMAMURTHY</u>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/29/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>RAYMOND L. KACZOROWSKI</u>			
				ADDRESS <u>2525 FLEET ST.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>11071</u>
BIRTH NO. <u>11071</u>		1. NAME OF DECEASED (Type or Print) Frances Gangi		
2. DATE AND HOUR OF DEATH November 27, 1971 3:30 PM M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION Good Samaritan Hospital 45		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 2616 Hudson Street		5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
8. DATE OF BIRTH 12-08-13		9. AGE (In years last birthday) 57		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		10B. KIND OF BUSINESS OR INDUSTRY DEPT. STORE		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Denniston		
14. MOTHER'S MAIDEN NAME Mary Janiewicz		15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 213-01-9689		17. INFORMANT MRS. ROSALIE BOCHINSKI		
ADDRESS 1108 HALLSTEAD RD		18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic malignant Melanoma		(B) DUE TO, OR AS A CONSEQUENCE OF: 3 months		
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED XXXX		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) XXX		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) XXX
21D. TIME OF INJURY (APPROX.) XXX		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? XXX
22. I certify that (I) (this hospital) attended the deceased from October 31, 1971 to November 27, 1971 that (I) (we) last saw the deceased alive on November 27, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE George H. Sack, Jr., M.D.				23B. DATE SIGNED November 27, 1971
23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D.		23D. ADDRESS 5600 Loch Raven Blvd. Balto., Md., 21205		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/1/71		24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEMETERY
24D. LOCATION (City, town, or county) (State) Baltimore MD.		25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		
ADDRESS 2525 FLEET ST.				



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

FRANK WESTON

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md.

B. COUNTY

6. SEX

male

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Bltto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

3/23/1900

10. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

170 W. Meadow Rd. 21225

11. BIRTHPLACE (State or foreign country)

Kansas

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

14B. KIND OF BUSINESS OR INDUSTRY

Retired

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

512-01-1934

18. INFORMANT

Mrs. McDonna Catterton 170 W Meadow Road

ADDRESS

21225

19.

41241425019

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Diabetes mellitus

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-28-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/1/71

24C. NAME OF CEMETERY or CREMATORY

Glen Haven Cemetery

24D. LOCATION (City, town, or county)

Ritchie Hwy, Glen Burnie Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1971

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

McGully Funeral Home 237 Patapsco Ave

ADDRESS

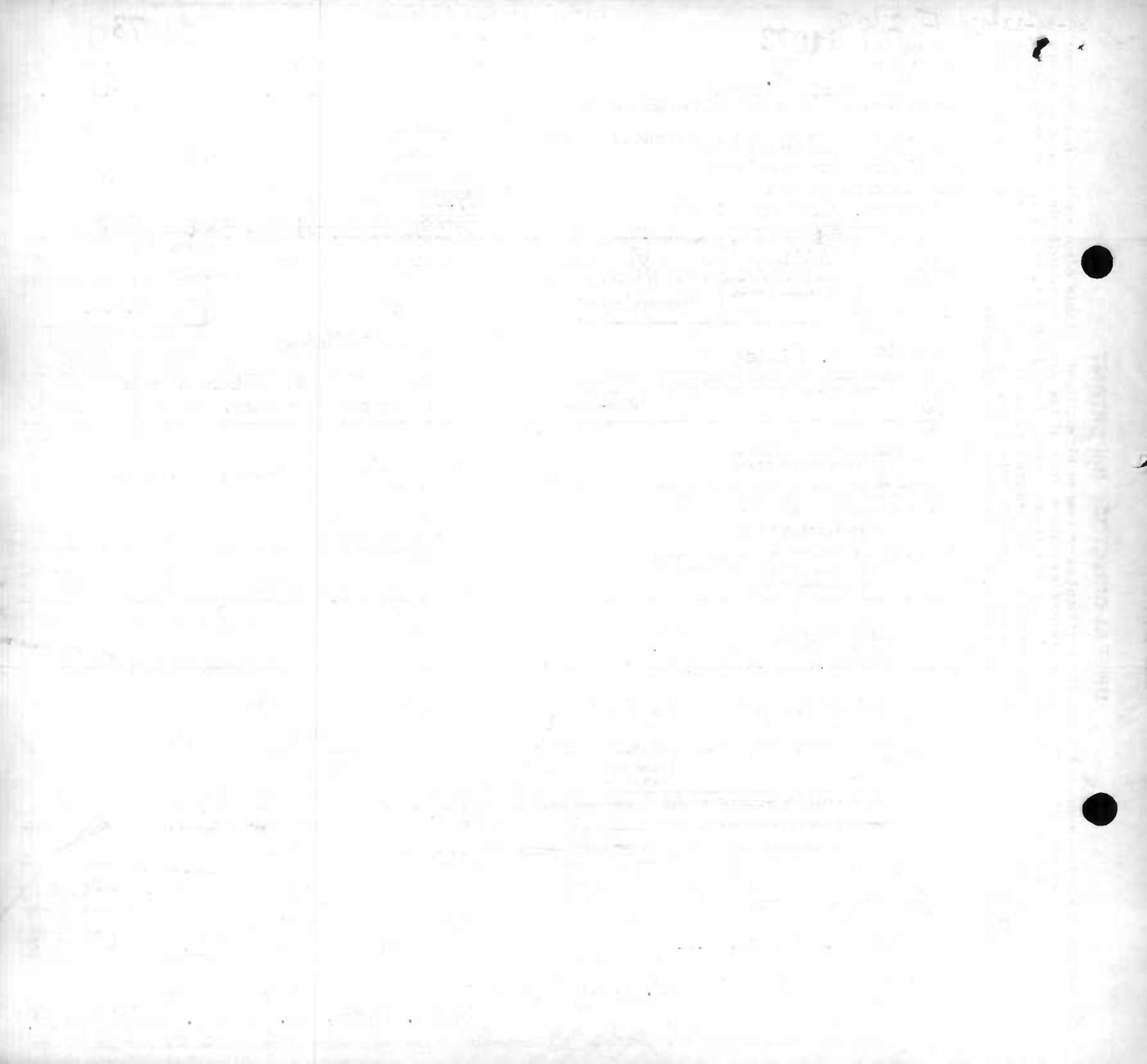
21225

STILL IN

STILL IN

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

34-64-13		F 260		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 11073	
BIRTH NO. 11073				BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print) Charles Fisher				2. DATE AND HOUR OF DEATH November 26, 1971 9:55 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2927 2927 East Baltimore Street 21224			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-03	9. AGE (In years last birthday) 68	10. UNDER 1 Yr. Months Days	11. UNDER 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10B. KIND OF BUSINESS OR INDUSTRY Unemployed			
13. FATHER'S NAME Winfield W. Fisher				14. MOTHER'S MAIDEN NAME Mary E. Biedenbach			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-01-9698A			
17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224							
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 11/26/71 19 to 11/26 1971 that (I) (we) last saw the deceased alive on 11/26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE Roland C. Einhorn, M.D. DEGREE 23B. DATE SIGNED 11/26/71 23C. PHYSICIAN'S NAME (Type) Roland C. Einhorn, M.D. DEGREE 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 11/29/71 24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971 25B. NAME OF REGISTRAR Robert E. Farber, Jr. 25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St. ADDRESS							



B426

71 11074

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11074

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Pablo Belacruz		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 11 Day 5 Year 1971 Hour 1:00 PM M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home and Hospital		3. DATE PRONOUNCED DEAD Month 11 Day 5 Year 1971 Hour 1:00 PM M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 301	
6. SEX Male	7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years lost birthday) 59	11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER 1624 E. Pratt Street	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS		19. E 887X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Craneo-cerebral injury (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1624 E. Pratt Street 301	
22D. TIME OF INJURY (APPROX.) 10 25, 1971 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? presumably fell	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Nov. 6, 1971					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-29-71		24C. NAME OF CEMETERY UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. NAME OF DIRECTOR ADDRESS	

N 857-000004070

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Russell Blake		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 11 Day 2 Year 71 Hour 11:53 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1956 N. Patterson Pk. Ave.		3. DATE PRONOUNCED DEAD Month 11 Day 2 Year 71 Hour 11:53 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 802	
9. DATE OF BIRTH 10. AGE (In years last birthday) 33 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER 1956 N. Patterson Pk. Avenue	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 492X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumothorax DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Pulmonary emphysema OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-29-71	
24C. NAME AND ADDRESS OF CREMATOR		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1971		25B. NAME OF REGISTRAR Robert E. Jarboe, M.D.	
25C. FUNERAL HOME OR ADDRESS		25D. MORTUARY SERVICE - BCHD	

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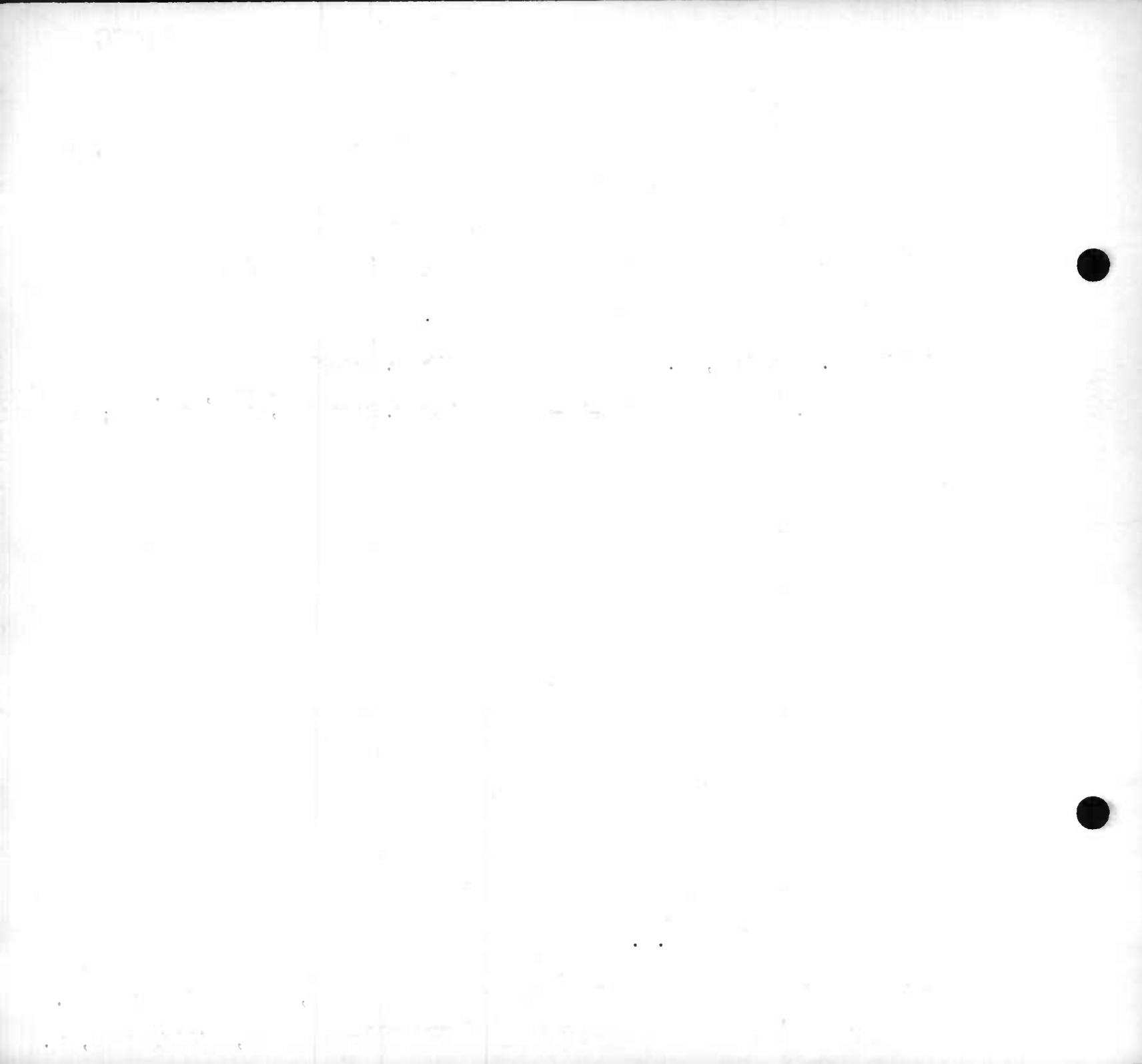
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. REG. NO. <u>71 11076</u>									
1. NAME OF DECEASED (Type or Print) <u>Sarah Virginia Glandius Crossley</u>					2. DATE AND HOUR OF DEATH <u>11/24/71</u> <u>12³⁵</u> P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>PRIT</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland 38 Hospital</u>					C. CITY OR TOWN <u>Chester town</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER <u>Route #1</u>				
5. SEX <u>F</u>	6. RACE <u>Can</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/16/17</u>	9. AGE (in years last birthday) <u>54</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William E. Bradley, Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Jennie M. Hurtt</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> <u>No.</u>					16. SOCIAL SECURITY NO. <u>221-10-2784</u>		17. INFORMANT <u>Newark, Del. Elias C. Crossley, 23 Maple Ave; Rosavelt</u>		
18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Recurrent Ca of Cy</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>6 yrs</u>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Recurrent Ca of Cy</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>pelvic Abscess</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>				
19A. DATE OF OPERATION <u>Oct 8, 1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Recurrent Ca of Cy</u>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>2</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 26</u> 19 <u>71</u> to <u>Nov 24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Nov 24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Lawrence Blumberg</u> M.D.					23B. DATE SIGNED <u>Nov 24, 1971</u>			23C. PHYSICIAN'S NAME (Type) <u>LAWRENCE BLUMBERG M.D.</u>	
23D. ADDRESS <u>University of Maryland Hospital</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/27/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Odd Fellows Cemetery</u>		24D. LOCATION <u>Smyrna, Kent Co; Del.</u>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Edward Fellows & Son, Millington, Md.</u>					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 71 11077REG. NO. 71 110771. NAME OF DECEASED
(Type or Print)

ROBERT SCORAH, JR.

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
NovDay
21,Year
1971

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**CERTIFICATE AMENDED**

University Hospital 12-20-71

3. DATE
PRONOUNCED DEADMonth
11Day
21Year
1971

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE Md.

B. COUNTY

Anne Rundel

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Shady Side

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

March 27, 1970

10. AGE (In years
last birthday)

1 yr

If Under 1 Yr. II Under 24 Hrs.
Months; Days; Hours; Min.

19

|

|

|

|

|

|

E. STREET AND NUMBER

5 Frederick Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

US

13. FATHER'S NAME

Robert V. Scorah

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Selina Turner

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mother same as # 5 above

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)~~Sudden Death in Infancy~~

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute bronchopneumonia complicated

by cerebral edema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-22-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/24/71

24C. NAME of CEMETERY or CREMATORY

Sacred Heart Cemetery

24D. LOCATION

(City, town, or county) (State)

Bushwood, St Mary's, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 1 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

W. Clarke Mattingley Leonardtown, Maryland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 11078

BIRTH NO. 11078

1. NAME OF DECEASED
(Type or Print)

CATHERINE I. CANAPP

2. DATE AND HOUR OF DEATH

11-28-71

12:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

MARYLAND

BALTIMORE

1307

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3825 CROWTHER ST - BALTIMORE, MD 21211

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

11/23/14

9. AGE (in years last birthday)

57

10. Under 1 Yr. Months: Days:

11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MACHINE-OPERATOR

10B. KIND OF BUSINESS OR INDUSTRY

Hooper & Son

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

BAKER

14. MOTHER'S MAIDEN NAME

XXXXXX Craig

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-14-3273

17. INFORMANT

JOHN CANAPP

ADDRESS

Balt, Md. 21211
1529 Union Ave

18. 199.0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

RESPIRATORY INSUFFICIENCY

(B) PULMONARY EMBOLISM

DUE TO, OR AS A CONSEQUENCE OF:

(C) METASTATIC CARCINOMA -

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0 -

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

-

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

-

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

-

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX)

-

(Month) (Day) (Year) (Hour)

-

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

-

22. I certify that (I) (this hospital) attended the deceased from 11-18-71 to 11-28-71 that (I) (we) last saw the deceased alive on 11-28-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-28-71

23C. PHYSICIAN'S NAME (Type)

ALFONSO RIVAS-PLATA

DEGREE

23D. ADDRESS

UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/1/71

24C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 1 1971

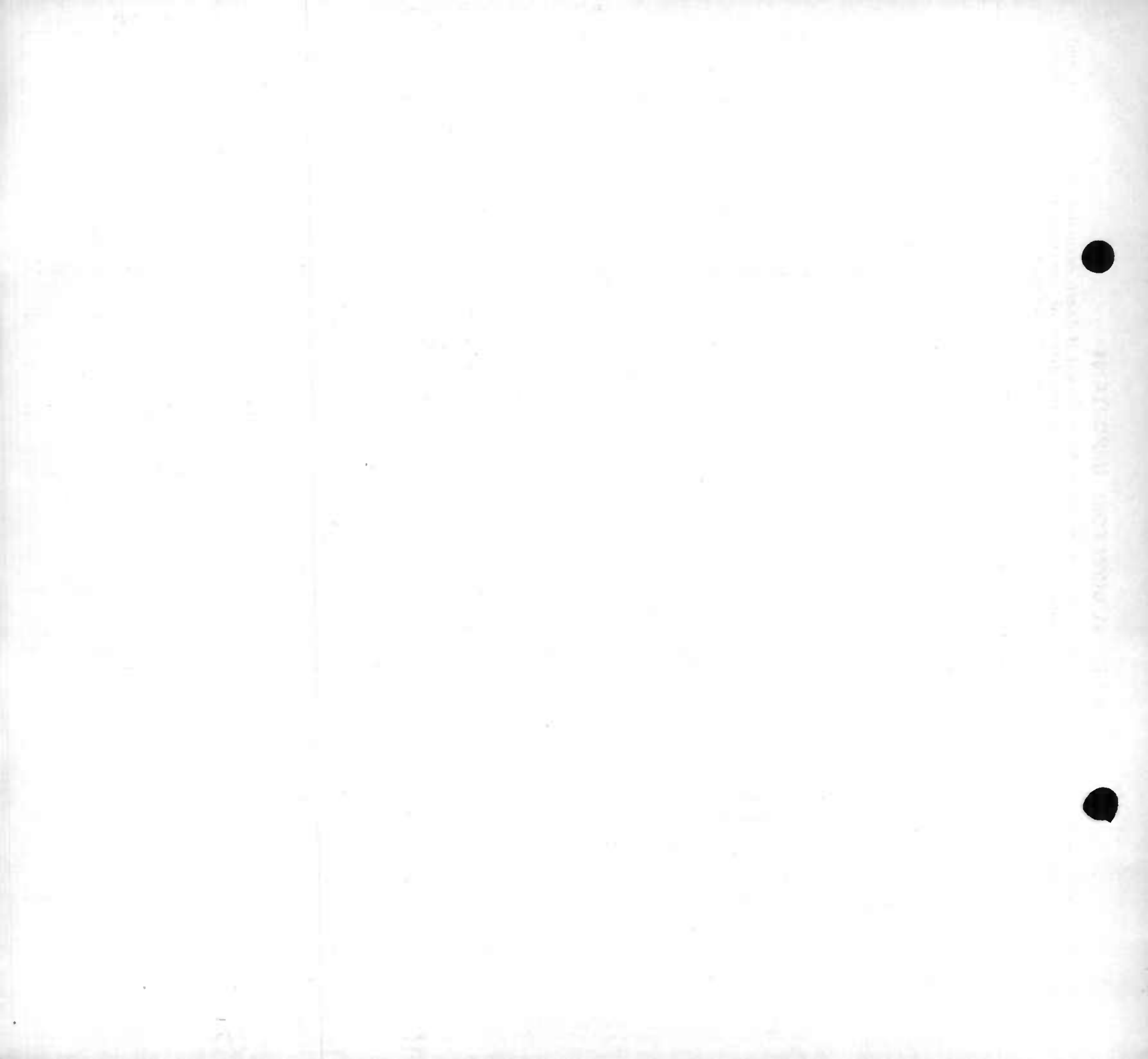
25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Donovan Funeral Home-3818 Roland Ave.

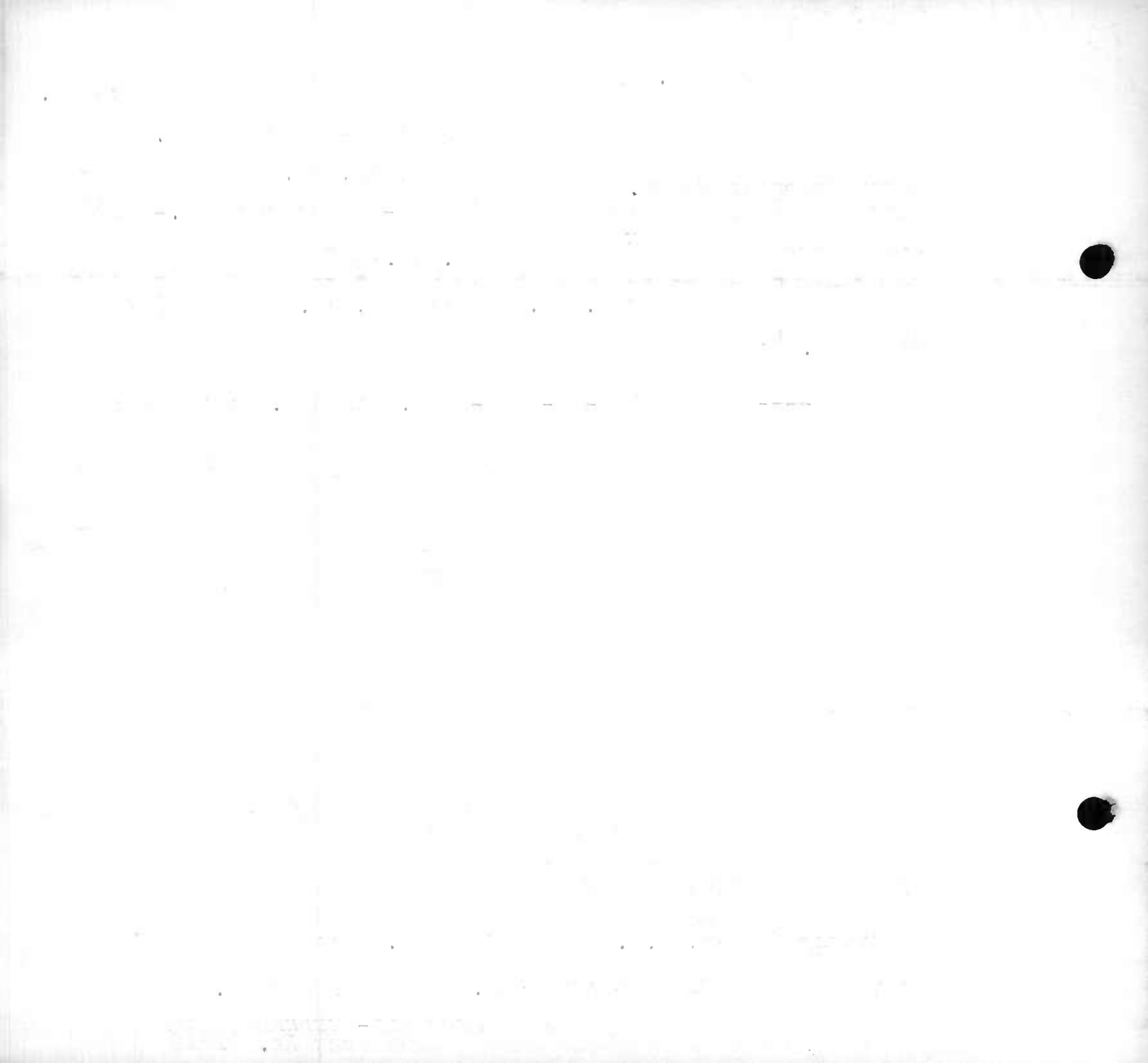
ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A 4161

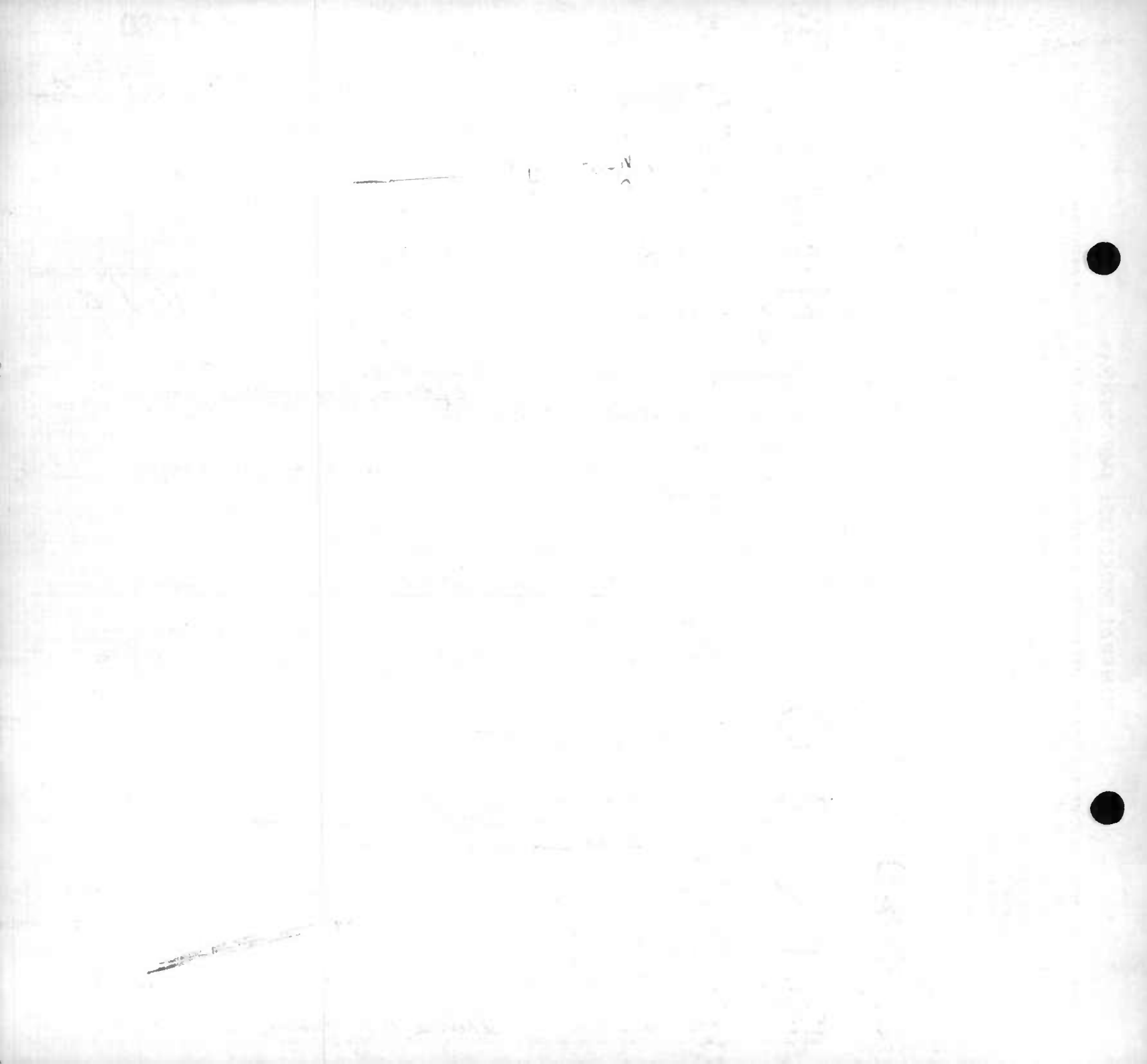
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11079	
BIRTH NO. 71 11079					
1. NAME OF DECEASED (Type or Print) FREDERICK B. ALBERT		2. DATE AND HOUR OF DEATH 11/25/71 8:05 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPT. CALVERT & 33RD STREETS		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND-BALTIMORE Co. B. COUNTY 5300 C. CITY OR TOWN PARKVILLE, Md. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2804 B- KINGSRIDGE Rd. - 21234			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11. 1917	9. AGE (In years and months) 54	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDIT SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY INA Ins. Co.		11. BIRTHPLACE (State or foreign country) FALLSTON, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH E. ALBERT			
14. MOTHER'S MAIDEN NAME REGINA BECKER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO			
16. SOCIAL SECURITY NO. 212-09-7779		17. INFORMANT ADDRESS Mrs. CLARA F. ALBERT (WIFE)			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery disease 10+ yrs		DUE TO, OR AS A CONSEQUENCE OF: (B) with 2 prior infarctions (C) and congestive failure			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/8 19 54 to 11/20 19 71 that (I) (we) last saw the deceased alive on 11/20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William R. Renner		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) WILLIAM RENNER, M.D.	
23D. ADDRESS 3222 St. PAUL STREET		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/29/71		24C. NAME of CEMETERY or CREMATORY WOODLAWN CEM.	
24D. LOCATION (City, town, or county) BALTO Co.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME	
25D. ADDRESS 6500 YORK Rd. 21212		25E. (State)			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11080</u>	
60-14-15		djs <u>T 235</u>		71 11080	
1. NAME OF DECEASED (Type or Print) <u>Teichman, Joseph</u>			2. DATE AND HOUR OF DEATH <u>Nov-29-1971</u> <u>8⁰⁰</u> (A.M.)		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Balt. City</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>712 S. Eagle St</u> 21224		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Balt City Hosp. D2W</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>4940 Eastern Ave Balt Md 21224</u>					
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-82</u>	9. AGE (In years last birthday) <u>89</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>conductor (railway)</u>			11. BIRTHPLACE (State or foreign country) <u>md.</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>717-07-8452</u>		
			17. INFORMANT <u>Baltimore City Hospitals Records</u> ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland</u>		
18. <u>431.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Inter cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>over 2</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>D. Pneumo & E. coli Aspiration Pneumonia</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>Nov-16-1971</u> to <u>Nov-29-1971</u> that (H) (we) last saw the deceased alive on <u>Nov-29-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (He) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. S. Merritt, MD</u> DEGREE			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Nov-29-1971</u>
23C. PHYSICIAN'S NAME (Type) <u>JAY E. MENITOVIE, MD</u> DEGREE			23D. ADDRESS <u>Balt. City Hosp. - 4940 Eastern Avenue Balt, Md 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>12-2-71</u>	<u>Oak Lawn</u>		<u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, R.D.</u>		25C. FUNERAL DIRECTOR <u>Thelma A. Hoffmann</u> ADDRESS <u>3218 Hudson St.</u>	



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71 11081

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11081

BIRTH NO.

1. NAME OF DECEASED (Type or Print) AGNES SCHMIDT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 264 S. Robinson St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 26 1971 8:45 p M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH April 22, 1907		10. AGE (In years last birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Martin		14. STREET AND NUMBER 264 S. Robinson St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		15. MOTHER'S MAIDEN NAME Agnes Resig	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-46-8745	
18. INFORMANT Mrs. Magdalene Swayne		ADDRESS 3101 Foster Ave	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 11-27-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-30-71	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Helma R. Hoffmann		ADDRESS 3218 Hudson St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

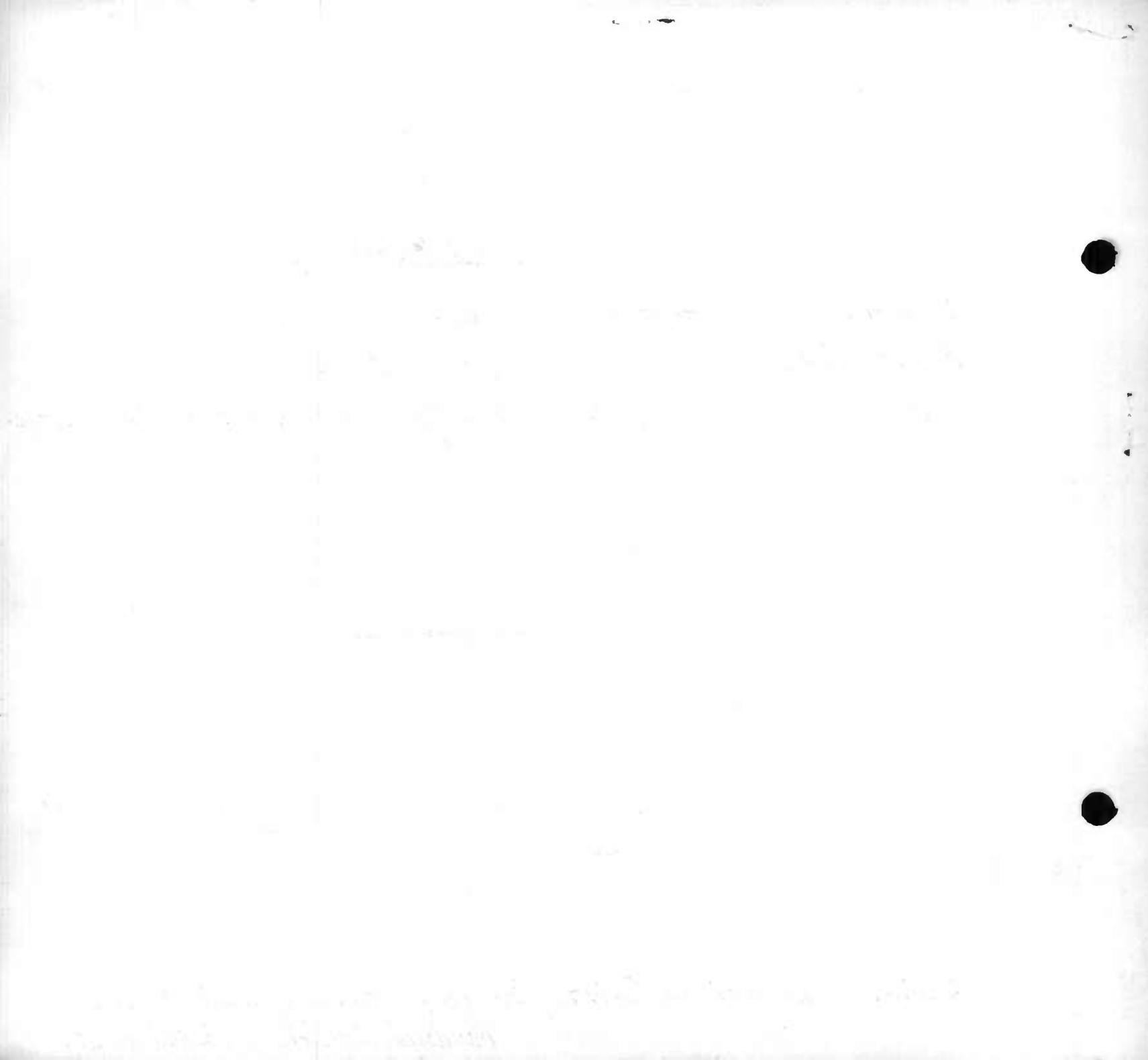
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11082</u>	
BIRTH NO. <u>71 11082</u>		1. NAME OF DECEASED (Type or Print) <u>STEVEN MROZINSKI</u>		2. DATE AND HOUR OF DEATH <u>November 29, 1971</u> <u>415</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2044 Gough Street</u>			4. USUAL RESIDENCE (Where deceased lived, II institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>201</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2044 Gough St.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/27/06</u>	9. AGE (In years last birthday) <u>65</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baltimore City</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sanitation Dept</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Francis Mrozinski</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Pilarski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-8465</u>	17. INFORMANT ADDRESS <u>Mrs. Helen Mrozinski, 2044 Gough St.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular Failure</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Curiosis -</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>+10</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Curiosis -</u>					
19A. DATE OF OPERATION <u>11-19-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-19-71</u> to <u>11-29-71</u> that (I) (we) lost saw the deceased alive on <u>11-19-71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Theodore T. Niznik</u>				23B. DATE SIGNED <u>11-29-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>T. NIZNIK</u>		23D. ADDRESS <u>429 S. Chester St.</u>		23E. DEGREE <u>MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/29/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Rosary</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. CITY, town, or county (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>M.F. SADOWSKI & Sons, 1808 EASTERN AVE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

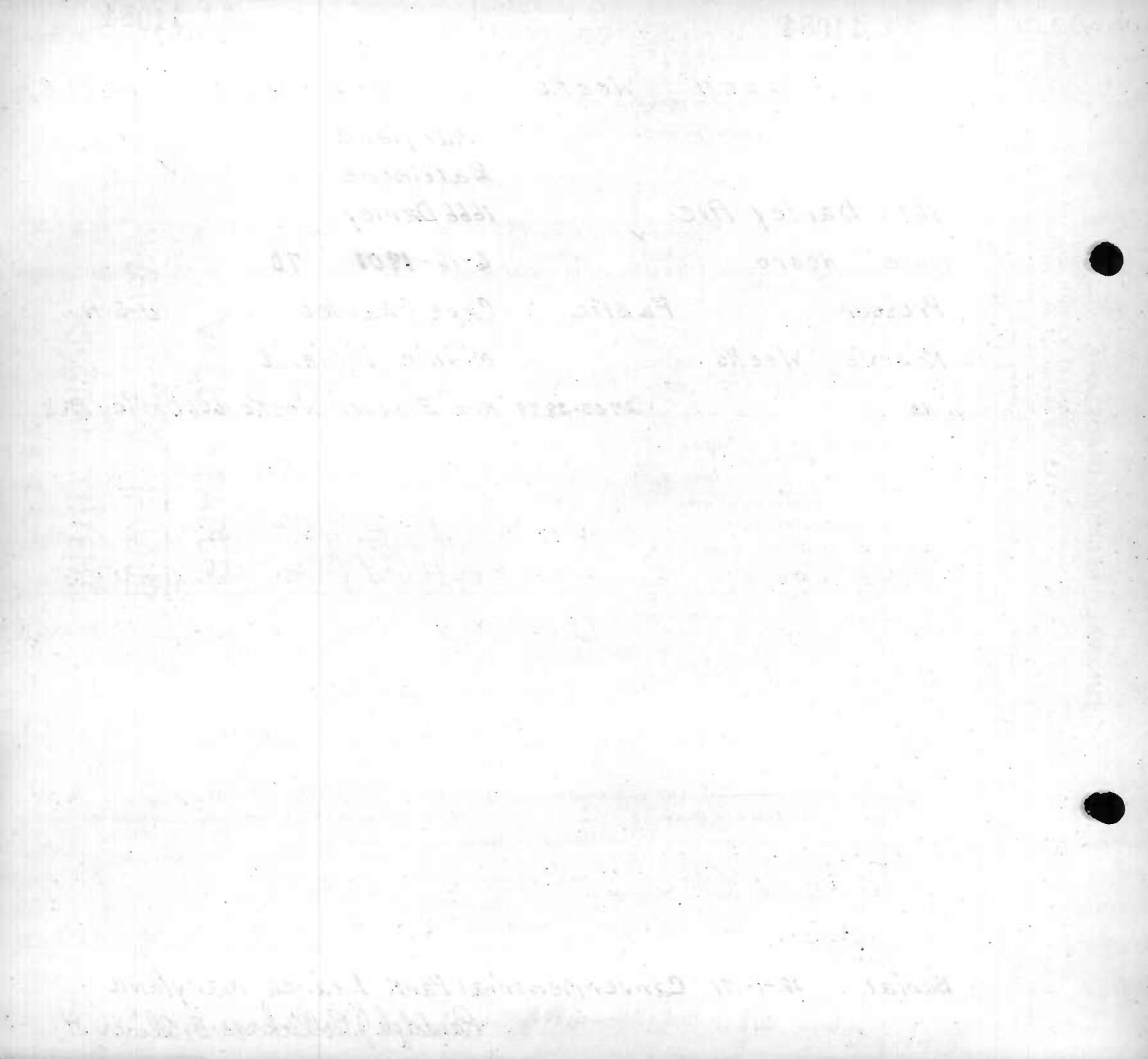
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11083	
CERTIFICATE OF DEATH					
BIRTH NO. 71 11083					
1. NAME OF DECEASED (Type or Print) <u>Ruth Teal</u>			2. DATE AND HOUR OF DEATH <u>11-24-71</u> <u>8:40 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1001</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Midtown Home</u> <u>90 808 St. Paul</u>			C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1202 Aisquith St.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-26-1930</u>	9. AGE (in years last birthday) <u>41</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Frank Teal</u>			14. MOTHER'S MAIDEN NAME <u>Mollie Byrd</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs. Phyllis Anderson 1510 N. Linwood Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>E929X1</u> <u>Cardiovascular Failure</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>Terminal Pneumonia</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiovascular Failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Blunt Force Injury to Head</u> (C) <u>Terminal Pneumonia</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hemiparesis</u>					
19A. DATE OF OPERATION <u>11-29-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain Contusion</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.) <u>Unknown</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>00-00</u>	
21D. TIME OF INJURY (APPROX) <u>11-28-70</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Unknown</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 19</u> 19 <u>71</u> to <u>Mar 24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Mar 24</u> 19 <u>71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>William D. Appleford</u>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>William D. Appleford</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>11-29-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>			25C. FUNERAL DIRECTOR <u>Randolph J. Collick 2431 E. Oliver St.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11084	
71 11084				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Frizzell Weeks		2. DATE AND HOUR OF DEATH 11-28-71 12:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 805		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1666 Darley Ave.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1901	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10B. KIND OF BUSINESS OR INDUSTRY Public		11. BIRTHPLACE (State or foreign country) Cape Charles	
13. FATHER'S NAME Robert Weeks		14. MOTHER'S MAIDEN NAME Minnie Dilliard		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 21743-2879		17. INFORMANT Mrs. Eleanor Weeks 1666 Darley Ave	
18. 433.91		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Cerebral Thrombosis		?	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Cerebral Arteriosclerosis		5 years	
		Generalized Arteriosclerosis		10 years	
		Uterine tract obstruction		3 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-15-71 to Nov 19-71 , that (I) (we) last saw the deceased alive on 10-15-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (dtd) (did not) view the body after death.					
23A. SIGNATURE Eugene Owens M.D.		23B. DATE SIGNED 11-29-71		23C. PHYSICIAN'S NAME (Type) Eugene H. Owens M.D.	
23D. ADDRESS 1735 E. Federal St Baltimore		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-1-71	
24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Randolph J. Collick		25D. ADDRESS 2431 E. Oliver St.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 299 432	
BIRTH NO. 71 11085		CERTIFICATE OF DEATH		71 11085	
1. NAME OF DECEASED (Type or Print) Chambers, Charles Eugene Sr.		2. DATE AND HOUR OF DEATH 11/28/71 5 35 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY -			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) USPHS HOSPITAL BALTIMORE, MD. 21211		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2009 Guard Ave					
5. SEX M	6. RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 12, 1901	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Machinest		10B. KIND OF BUSINESS OR INDUSTRY Tool and Die		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Chambers			
14. MOTHER'S MAIDEN NAME Elizabeth Pallhorn		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 212 075461		17. INFORMANT Mr. Charles E. Chambers Jr. Box 2955 Md 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Acute CARDIORESPIRATORY FAILURE & Pulmonary Edema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Cardiac Disease and Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Severe Cardiovascular Atherosclerotic Disease Chronic (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal Acute & Chronic	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Renal Failure & Uremia				Recent	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) apintan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert R. Wright, MD		23B. DATE SIGNED 11/28/71		23C. PHYSICIAN'S NAME (Type) ROBERT R. WRIGHT, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-30-71		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Baltimore Co. Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, MD	
25C. FUNERAL DIRECTOR Surgee Funeral Home		25D. ADDRESS 3631 Falls Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11086	
BIRTH NO. 71 11086 <i>Carroll Co. Md.</i>		1. NAME OF DECEASED (Type or Print) John Warehime		2. DATE AND HOUR OF DEATH 11/26/71 5:08 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Carroll	
		C. CITY OR TOWN Westminister		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 71 Hook Road			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-71	9. AGE (In years lost birthday) 27 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GERALD WAREHIME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 748.61 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PROGRESSIVE CARDIAL STANDSTILL ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PROGRESSIVE HYPOXIA AND ACIDOSIS HYPOPLASTIC LUNGS, Congenital Heart Disease diaphragmatic hernia					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 11-25-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diaphragmatic hernia		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6 PM 11-25-71 to 5 PM 11-26-71 that (I) (we) last saw the deceased alive on 5 PM 11-26-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David K. Bone M.D.				23B. DATE SIGNED 11-26-71	
23C. PHYSICIAN'S NAME (Type) DAVID K. BONE				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11/27/71		24C. NAME OF CEMETERY OR CREMATORY Johns Hopkins Hospital	
				24D. LOCATION (City, town, or county) (State) 601 N Broadway Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11087

BIRTH NO. 71 11087

1. NAME OF DECEASED
(Type or Print)

EAGER, Sue

2. DATE AND HOUR OF DEATH

11-29-71

3 45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

GOOD SAMARITAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

PICKERSILL HOME MARYLAND, BALTO.

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

TOWSON

YES ☐

NO ☒

E. STREET AND NUMBER

615 Chestnut Ave

5300

5. SEX

F

6. RACE

CAUC

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

04-06-96

9. AGE (In years last birthday)

75

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home Maker

10B. KIND OF BUSINESS OR INDUSTRY

OWN Home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARRY A. COLLISON

14. MOTHER'S MAIDEN NAME

ELIZABETH WILSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-12-4072

17. INFORMANT

ADDRESS

PICKERSILL HOME SAME AS # 4

18. 153.8 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Metastatic Carcinoma of colon

6 M.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At Work ☐

Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (we) (this hospital) attended the deceased from 11/02 19 71 to 11/29 19 71, that (I) (we) last saw the deceased alive on 11/29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Jose Martinez

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/29/71

23C. PHYSICIAN'S NAME (Type)

Jose MARTINEZ

DEGREE

23D. ADDRESS

GOOD SAMARITAN HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12-1-71

24C. NAME of CEMETERY or CREMATORY

BALTIMORE CEMETERY

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

DEC 1 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks Towson, Inc.

ADDRESS

Towson, Md.

SP021

SP021

A 5361

71 11088

BALTIMORE CITY HEALTH DEPARTMENT

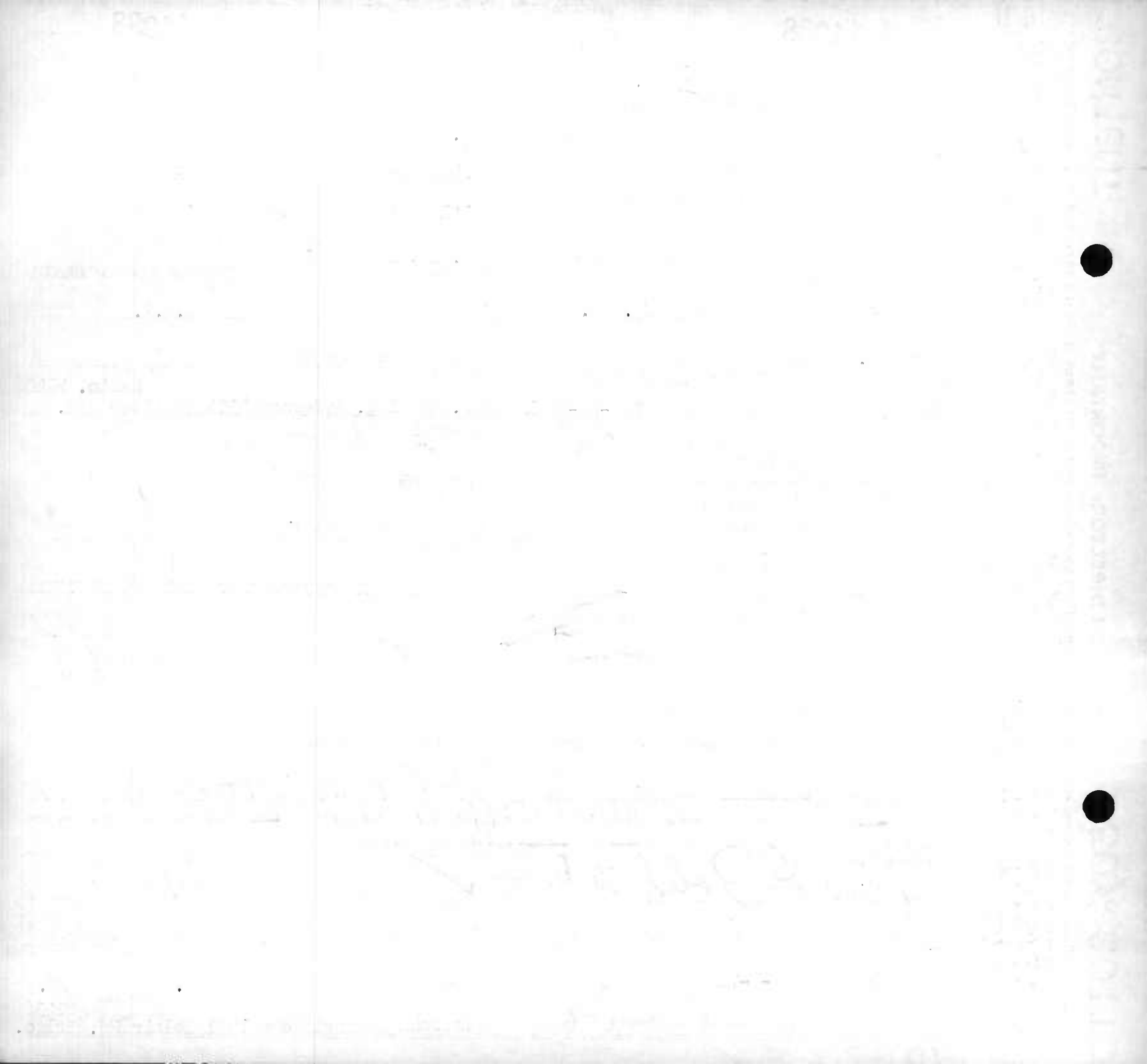
CERTIFICATE OF DEATH

REG. NO. 71 11088

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

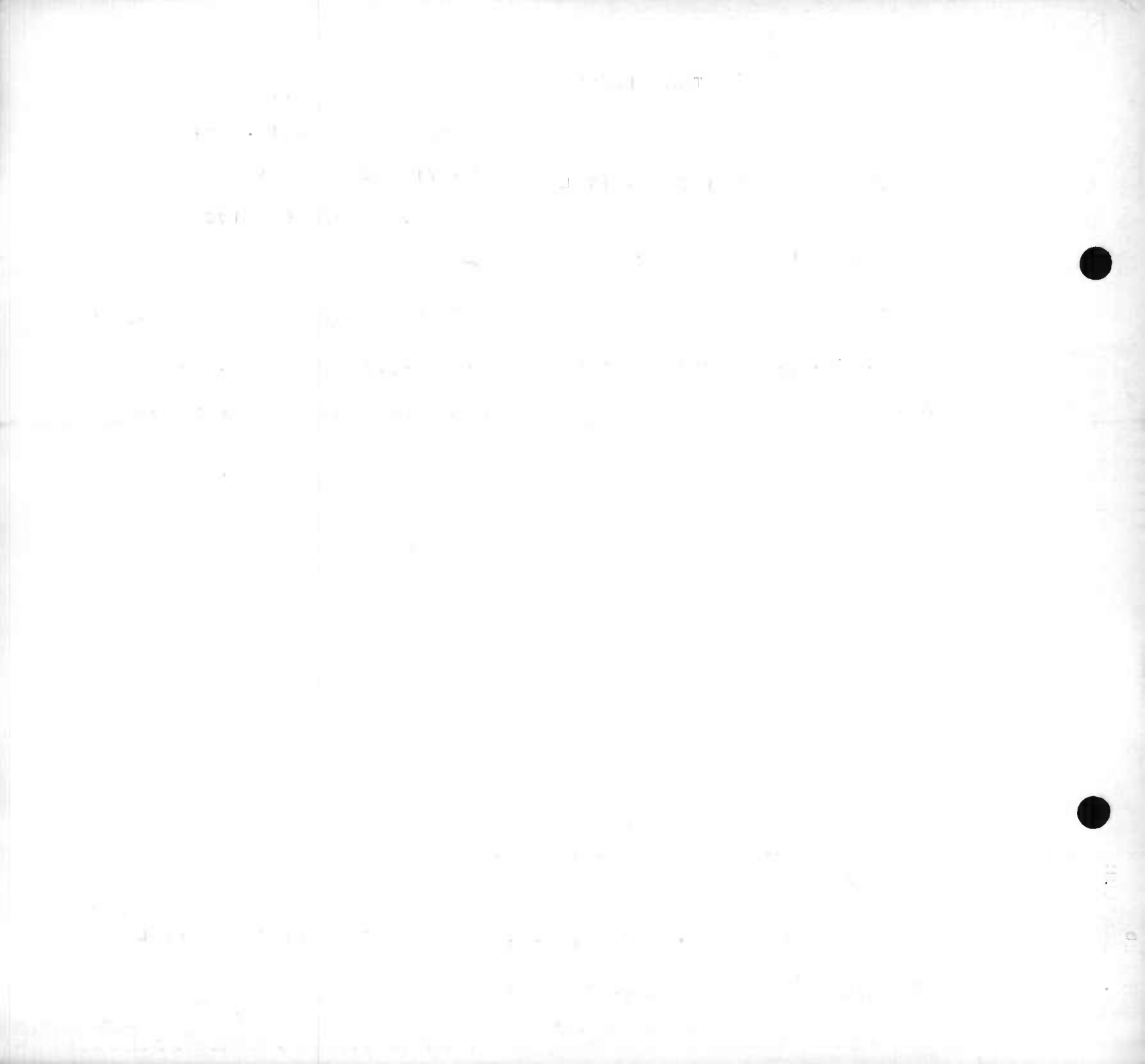
FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 71 11088		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11088	
1. NAME OF DECEASED (Type or Print) Charles E. Anderson		2. DATE AND HOUR OF DEATH 11-27-71 1:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2641			
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER 4321 Hamilton Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1908	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Kemp Mfg. Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry L. Anderson		14. MOTHER'S MAIDEN NAME Anna Mae Schumacher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-1101		17. INFORMANT Mrs. Ethel G. Anderson 4321 Hamilton Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic Interstitial Pulmonary Fibrosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cow Pulmonary -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: 1 year			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Inotify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 1, 1968 to November 27, 1971 that (I) (we) last saw the deceased alive on November 27, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin F. Polek, M.D.		23B. DATE SIGNED 11/29/71		23C. PHYSICIAN'S NAME (Type) Melvin F. Polek M.D.	
23D. ADDRESS 3603 Belair Road Balto. Md.		23E. FUNERAL DIRECTOR Lassahn Funeral Home 7101 Belair Rd. Balto.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-1-71		24C. NAME of CEMETERY or CREMATORY Gardens Of Faith Cemetery	
24D. LOCATION Overlea Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Lassahn Funeral Home 7101 Belair Rd. Balto.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11089	
BIRTH NO. 71 11089		1. NAME OF DECEASED (Type or Print) BERTHA RIESSLER		2. DATE AND HOUR OF DEATH 11/28/71 5:12 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 627 N. WOODWARD DRIVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-92	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHANN WERNER		14. MOTHER'S MAIDEN NAME MAGDALENE BUHLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT ADDRESS ERIC RIESSLER 358 OBERLE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412:4 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular Arrest (B) ASCVD (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4:30 PM 11/28/71 19 to 5:12 PM 11/28/71 19 that (I) (we) last saw the deceased alive on 11/28/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walker L. Yerkes, M.D.		23B. DATE SIGNED 11/28/71		23C. PHYSICIAN'S NAME (Type) WALTER L. GERBER, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/2/71		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.	
24D. LOCATION (City, town, or county) BALTO. MD		24E. DATE REC'D BY HEALTH DEPT. DEC 1 1971		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. SIGNATURE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11090	
1. NAME OF DECEASED (Type or Print) LOWE, FLORA BELLE				2. DATE AND HOUR OF DEATH NOVEMBER 26 1971 1 5:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION WILKENS & CATON AVENUES		A. STATE MD.		B. COUNTY HOWARD COUNTY	
CITY OR TOWN ELLCOTT CITY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 8012 MAIN STREET			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 24 08	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME LOUIS REDMOND			14. MOTHER'S MAIDEN NAME ALICE CARTER REDMOND				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO			16. SOCIAL SECURITY NO. 215-38-4699		17. INFORMANT ST. AGNES HOSPITAL MEDICAL RECORDS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 180X I methotatic corci- noma of the cervix			CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
			(B) DUE TO, OR AS A CONSEQUENCE OF:				
			(C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 23 19 71 to NOVEMBER 26 19 71 that (I) (we) last saw the deceased alive on NOVEMBER 26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>						23B. DATE SIGNED 11 26 71	
23C. PHYSICIAN'S NAME (Type) JOSE APITER		MD		23D. ADDRESS ST AGNES HOSPITAL-BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/71		24C. NAME of CEMETERY or CREMATORY Forest Oak		24D. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, MD.		25C. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 11091

BIRTH NO. 71 11091

1. NAME OF DECEASED
(Type or Print)

Richard Clark Jenkins

2. DATE AND HOUR OF DEATH

November 29, 1971

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

2820 Hinsdale Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2820 Hinsdale Drive

5. SEX

M.

6. RACE

W.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10/9/12

9. AGE in years (last birthday)

59

10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Welder

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Richard F. Jenkins

14. MOTHER'S MAIDEN NAME

Alice Lawton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

No

16. SOCIAL SECURITY NO.

213-07-3962

17. INFORMANT

Mrs. Yvonne W. Jenkins ADDRESS Drive

2820 Hinsdale

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary Thrombosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

out Sch. C-V. disease

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/1/71 to 12/1/71 that (I) (we) last saw the deceased alive on 11/1/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. H. Goodman

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

J. H. Goodman M.D.

23D. ADDRESS

9 S. Highland Ave. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/2/71

24C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery, Baltimore, Maryland

24D. LOCATION

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 1 1971

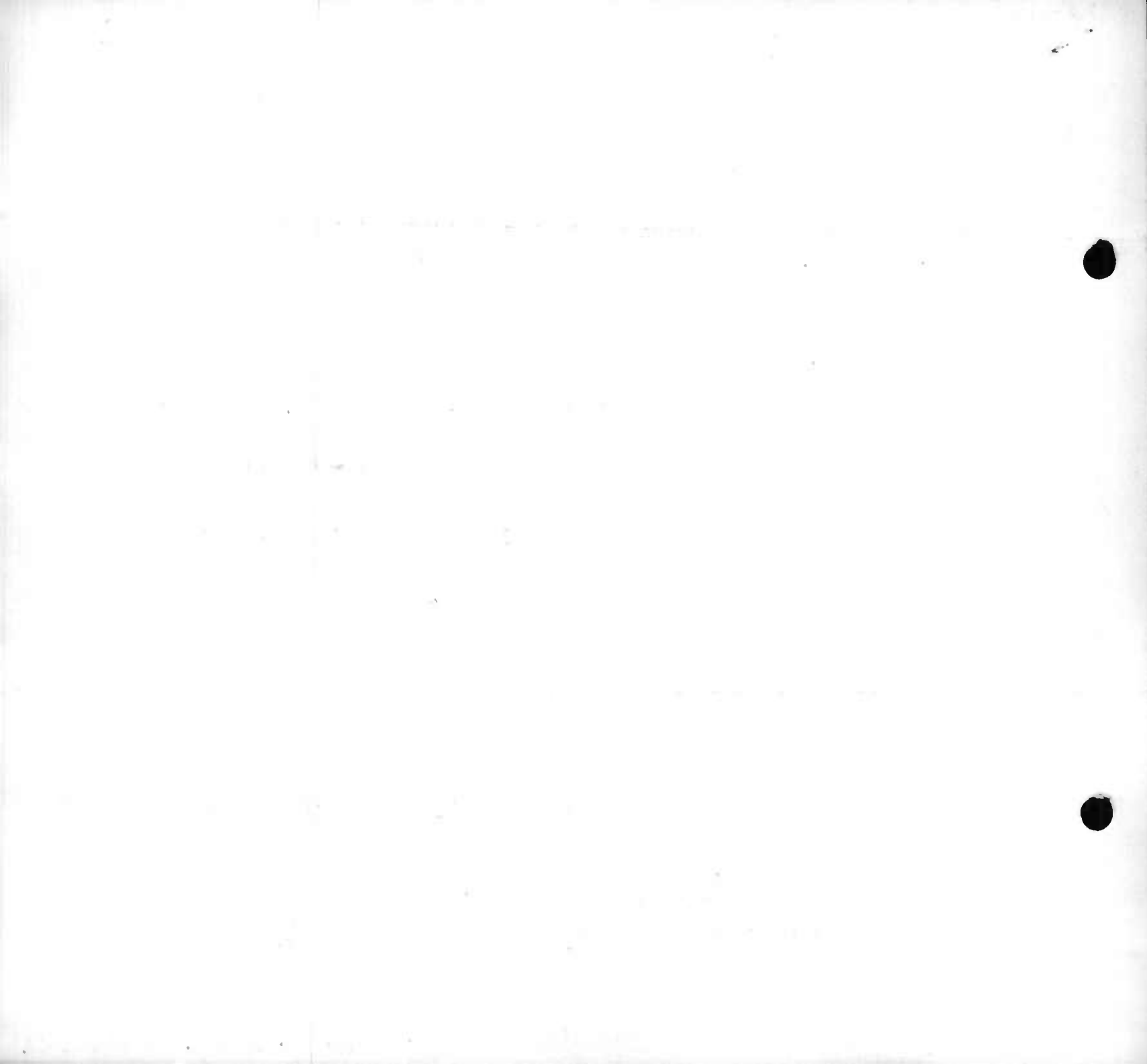
25B. NAME OF REGISTRAR

Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11092	
BIRTH NO. 71 11092		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mann, Thomas</u>		2. DATE AND HOUR OF DEATH <u>11/29/71 @ 7:45 pm</u> <u>1:45</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Good Samaritan Hospital</u> <u>45</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1030 W. 38th St.</u>		8th Floor	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/04</u>	9. AGE (In years last birthday) <u>67</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Billiard Hall Mgr.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u> <u>not known</u>		11. BIRTHPLACE (State or foreign country) <u>not known</u> Md.	
13. FATHER'S NAME <u>Louis Mann</u>		14. MOTHER'S MAIDEN NAME <u>? Burkins</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>not known</u>		16. SOCIAL SECURITY NO. <u>24-01-2318</u>		17. INFORMANT <u>Violet Mann - 1030 W. 38th St.</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Carcinoma of lung</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>4 metastases</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>10/25</u> 19 <u>71</u> to <u>11/29</u> 19 <u>71</u> that (I) <u>we</u> last saw the deceased alive on <u>11/29</u> 19 <u>71</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Richard J. Owellen M.D.</u>				23B. DATE SIGNED <u>11/29/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard J. Owellen, M.D.</u>		23D. ADDRESS <u>Good Samaritan Hosp.-Loch Raven Blvd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/3/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>	
24D. LOCATION <u>Baltimore,</u>				<u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Violet E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Donovan Funeral Home-3818 Roland Ave.</u>	
				ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11093

BIRTH NO. 71 11093		1. NAME OF DECEASED (Type or Print) WELCH, MARY FRANCES		2. DATE AND HOUR OF DEATH NOVEMBER 27, 1971 2:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 190221223		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1320 HOLLINS STREET	
6. SEX FEMALE	7. RACE CAUCASIAN	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 12/28/16	10. AGE (in years lost birthday) 54	11. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXX Spinner Cotton Mill		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ----- Markalonis		14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 217-05-6466		17. INFORMANT WILKENS AVES BALTO MD 21229 ST AGNES HOSPITAL'S RECORDS, CATON &		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHOPNEUMONIA (B) DUE TO, OR AS A CONSEQUENCE OF: SMOKE INHALATION (C) DUE TO, OR AS A CONSEQUENCE OF: BURN CHRONIC OBSTRUCTIVE LUN DISEASE YEARS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 HRS 120 HRS 120 HRS	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		21. DATE OF OPERATION 11/22/71		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		25. WHERE DID INJURY OCCUR? 1320 HOLLINS ST., BALTO., 21229	
26. TIME OF INJURY (Month) (Day) (Year) (Hour) 11/22/71 200		27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		28. HOW DID INJURY OCCUR? SMOKING IN BED	
29. I certify that (X) (this hospital) attended the deceased from NOVEMBER 23 19 71 to NOVEMBER 27 19 71; that (X) (we) lost saw the deceased alive on NOVEMBER 27 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (we) view the body after death.		30. SIGNATURE F.N. Pratt M.D.		31. DATE SIGNED 11/27/71	
32. PHYSICIAN'S NAME (Type) F.N. Pratt M.D.		33. ADDRESS ST. AGNES HOSPITAL		34. DATE 12/1/71	
35. BURIAL CREMATION, REMOVAL (Specify) Burial		36. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		37. LOCATION (City, town, or county) Baltimore, Maryland	
38. DATE REC'D BY HEALTH DEPT. DEC 1 1971		39. NAME OF REGISTRAR Robert E. Taylor, M.D.		40. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Stricker Streets 21223	

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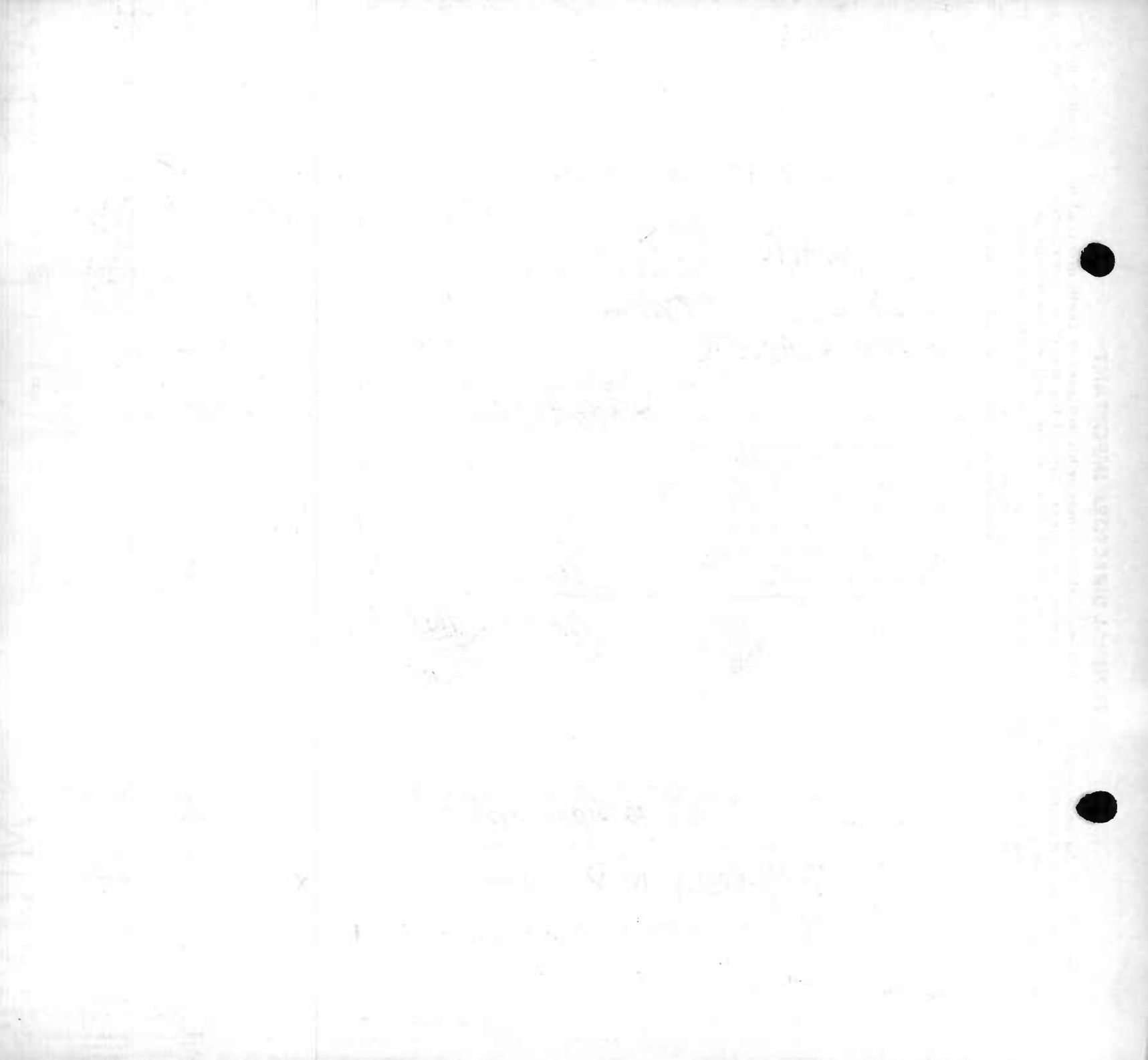
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

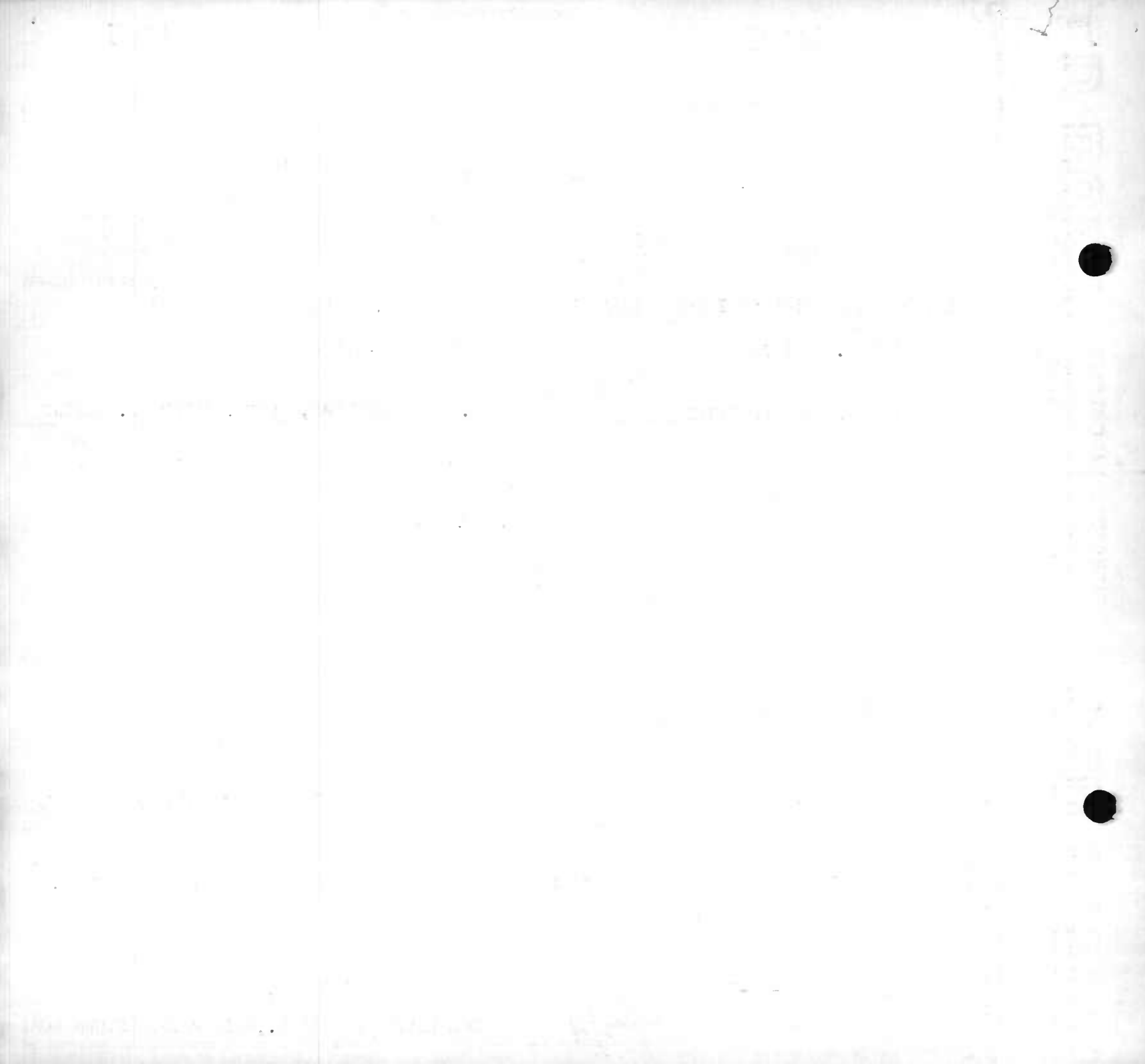
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11094	
BIRTH NO. 71 11094		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Blottenberger, Lilly May		2. DATE AND HOUR OF DEATH 12:21 pm. 11/29/71 Mon.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY 2303			
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GEN. Hosp.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
43		E. STREET AND NUMBER 1707 Clarkson St. Balto Md 21230			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-94	9. AGE (In years last birthday) 77	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) MARYLAND, Balto.	
13. FATHER'S NAME ADAM GLASSER		14. MOTHER'S MAIDEN NAME MARGARET WABER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-462-B		17. INFORMANT Eva F. Maskiewicz (Daughter) 21230 1704 S. Harwood St. Baltimore	
18. 410.9 14250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Emboli. (B) Acute Myocardial Infarction (C) Arteriosclerotic Cardiovascular Disease Diabetic Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from 11-28-71 to 11-29-1971 that (I) (we) last saw the deceased alive on 12:21 pm. 11/29/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Tan Yu Chen M.D.		23B. DATE SIGNED 11/29/71		23C. PHYSICIAN'S NAME (Type) TAN YU CHEN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 2, 1971		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore		24E. FUNERAL DIRECTOR CURTIS E. EVANS			
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. ADDRESS 1400 S. CHARLES ST. BALTO MD 21230	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11095	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) GOODMAN, JACK.		2. DATE AND HOUR OF DEATH 11/29/71 6:15 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL - BALTIMORE				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3927 Chaffey Rd Randallstown			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/25/34	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPERTY PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY SALVAGE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID H. GOODMAN				14. MOTHER'S MAIDEN NAME ELLA GREENBERG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREAN CONFLICT		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. CAROL GOODMAN, 3927 CHAFFEY RD. #21133			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF: Acute MI (B) DUE TO, OR AS A CONSEQUENCE OF: C. A. D		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5:15 - 6:15 AM	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/19 1971 to 11/29 1971 that (I) (we) last saw the deceased alive on 11/28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE K. Michaelides M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/29/71	
23C. PHYSICIAN'S NAME (Type) K. Michaelides				23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-30-71		24C. NAME of CEMETERY or CREMATORY MIKRO KODESH BETH ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11096	
BIRTH NO. 71 11096		1. NAME OF DECEASED (Type or Print) HELEN HURWITZ		2. DATE AND HOUR OF DEATH NOV 27/71 10 45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2841		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3703 Marmion Ave			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female 6. RACE White			E. STREET AND NUMBER 3703 MARMION AVE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 23, 1904		9. AGE (In years last birthday) 67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) HARTFORD, CONN	
13. FATHER'S NAME ISAAC TUCKER			14. MOTHER'S MAIDEN NAME CELIA MARCOLI'S		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT MISS DORA TUCKER - 6810 PARK HTS AVE
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ant myocardial infarction			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Recurrent coronary thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to 11/27/71 that (I) we lost saw the deceased alive on 11/27/71 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.					
23A. SIGNATURE Milton Kirsh				23B. DATE SIGNED 11/28/71	
23C. PHYSICIAN'S NAME (Type) MILTON KIRSH				23D. ADDRESS 4600 W. NORTHERN PKWY.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/30/71		24C. NAME OF CEMETERY OR CREMATORY ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Sgt. J. J. ... - 6010 ...	

Wm. H. H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11097

BIRTH NO. 71 11097

1. NAME OF DECEASED
(Type or Print)

ROBERT B. STECKER, Sr.

2. DATE AND HOUR OF DEATH

11-29-71 1:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)35 CHURCH HOME &
HOSPITAL.4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

MD

702

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2615 E. Monument St. 21205

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-28-1897

9. AGE (In years
last birthday)

73

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETD. U.S. GOV. DEPT. OF DEFENSE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FREDERICK STECKER

14. MOTHER'S MAIDEN NAME

MARY BERLAU

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

WW I Yes.

16. SOCIAL
SECURITY NO.

216 10 1911

17. INFORMANT

ADDRESS

Ethel Stecker (wife) same address

18. 492X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE CARDIO RESPIRATORY
DUE TO, OR AS A CONSEQUENCE OF: FAILURE

1 1/2 day.

(B) CHR. PUL. MODULAR FIBROSIS.
DUE TO, OR AS A CONSEQUENCE OF:

(C) EMPHYSEMA

6 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-26-1971 to 11-29-1971
that (I) (we) last saw the deceased alive on 11-29-1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

V. J. Sallaway, M.D.

Attending
Phys.Med.
DirectorStaff
Phys. ☒

23B. DATE SIGNED

11-29-71

23C. PHYSICIAN'S
NAME (Type)

DR. KRZCJ

23D. ADDRESS

CHCH.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12/2/71

24C. NAME of CEMETERY or CREMATORY

Moreland Memorial Pk. Cemetery

24D. LOCATION

Balto. Md.

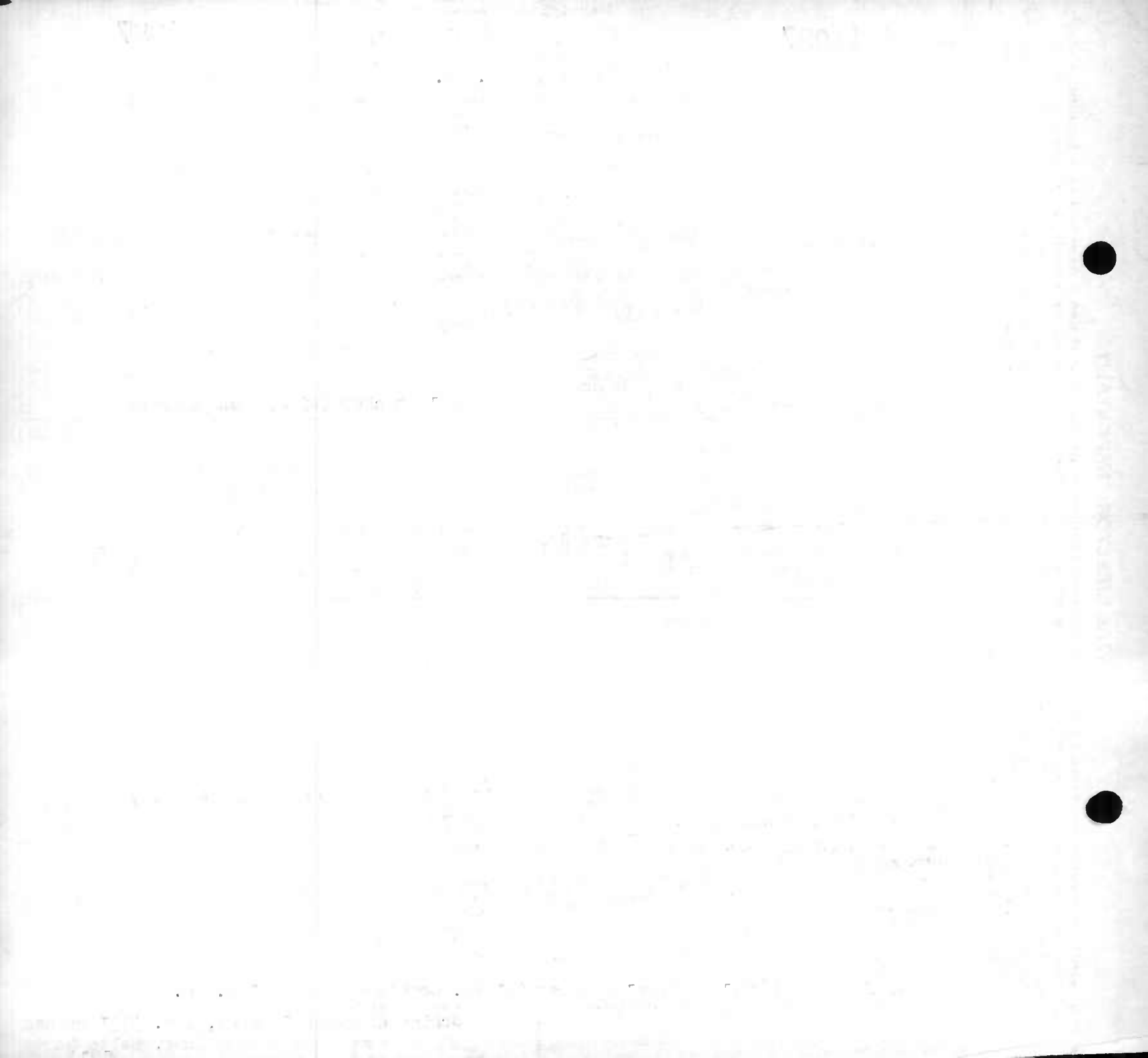
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Homes, Inc. 3331 Brehms
Lane, Balto Md

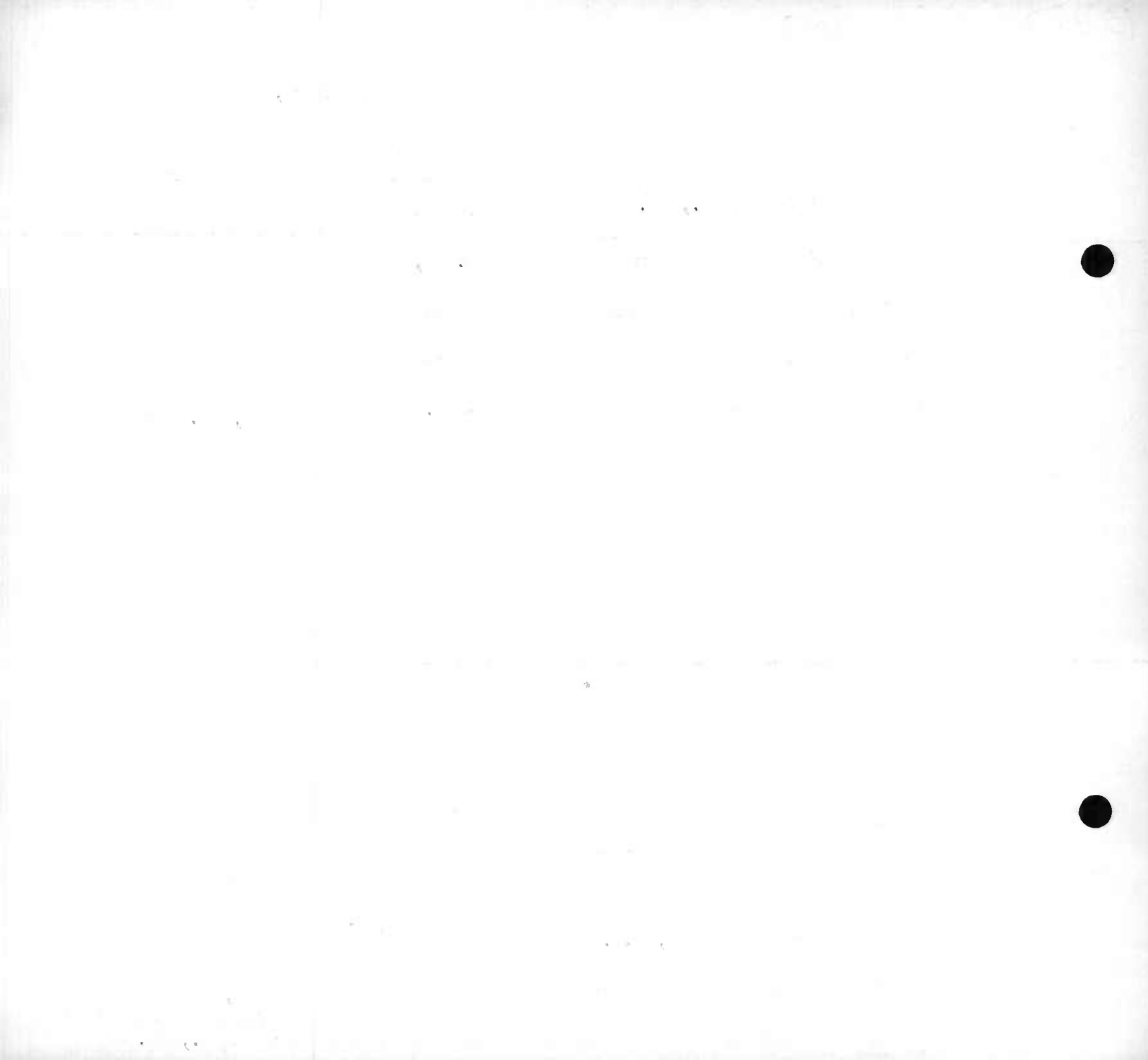


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

13650

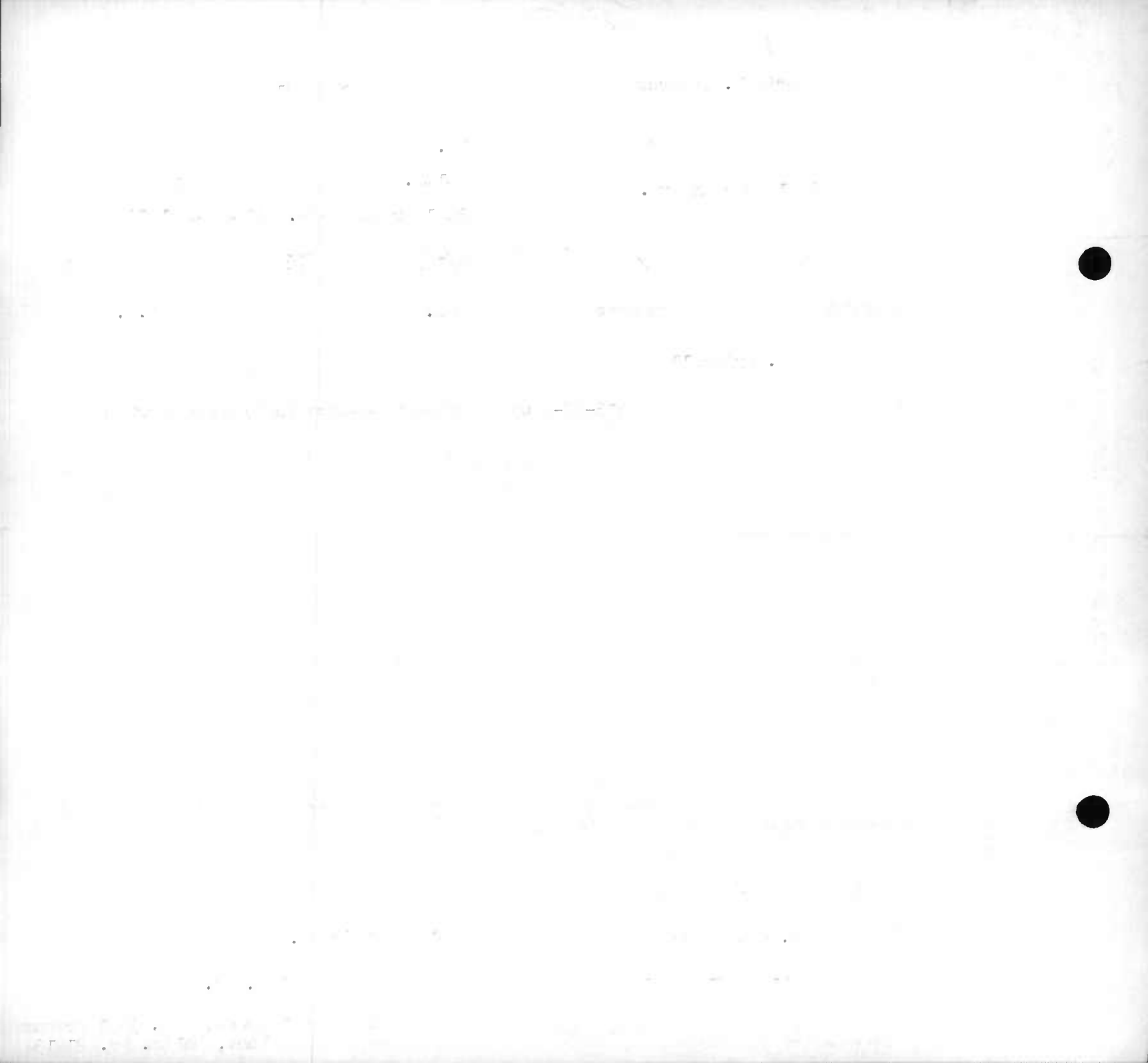
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11098</u>	
71 11098				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Raymond Browne</u>		2. DATE AND HOUR OF DEATH <u>November 29, 1971</u> <u>4 P. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2544</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3604 7th Street Balto., Md. 21225</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Oct. 27, 1889</u>		9. AGE (in years last birthday) <u>82</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert Browne</u>		14. MOTHER'S MAIDEN NAME <u>Ella</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 24 2331</u>		17. INFORMANT <u>Mary P. Meyd</u> ADDRESS <u>412 Church Street Baltimore, Md. 21225</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>myocardial infarct</u>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>arteriosclerosis - coronary & cerebral</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1967</u> to <u>April 1971</u> that (I) (we) last saw the deceased alive on <u>4-3-1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Schintzer</u>		23B. DATE SIGNED <u>11-30-71</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>Eugene Schintzer, M.D.</u>		23D. ADDRESS <u>3904 South Hanover Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-3-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>	
24D. LOCATION (City, town, or county) <u>Glen Burnie, Maryland</u>		(State) _____			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jelen, M.D.</u>		25C. FUNERAL DIRECTOR <u>McCully Funeral Home</u> ADDRESS <u>130 East Ford Avenue Balto., Md. 21230</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

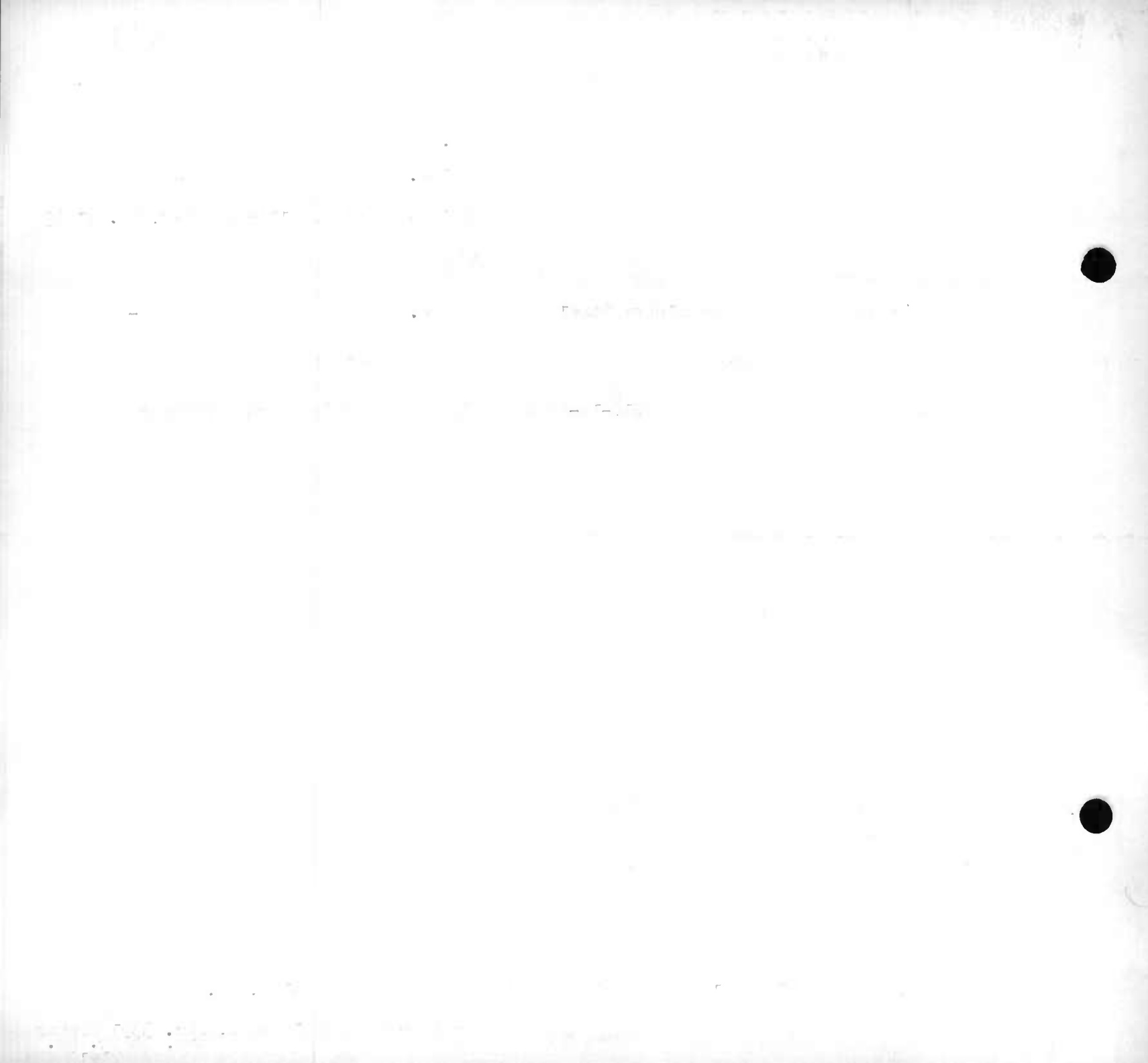
BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 71 11099				CERTIFICATE OF DEATH		REG. NO. 71 11099	
1. NAME OF DECEASED (Type or Print) Marie L. DeMarco				2. DATE AND HOUR OF DEATH 11/27/71 2 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3021 Brendan Ave.		A. STATE Md.		B. COUNTY 2633	
				C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3021 Brendan Ave. Balto Md 21213			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/95	9. AGE (In years last birthday) 76	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John E. Driscoll				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-32-0065		17. INFORMANT ADDRESS Anthony DeMarco (son) same address	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Hypertension C.V.D. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 11-18		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-18 to 11-27 19 71 and that (I) (we) last saw the deceased alive on 11-18 19 71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. John Moores				23B. DATE SIGNED 11-29-71		23C. PHYSICIAN'S NAME (Type) Dr. John Moores	
23D. ADDRESS 3105 Belair Rd.				23E. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/30/71		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

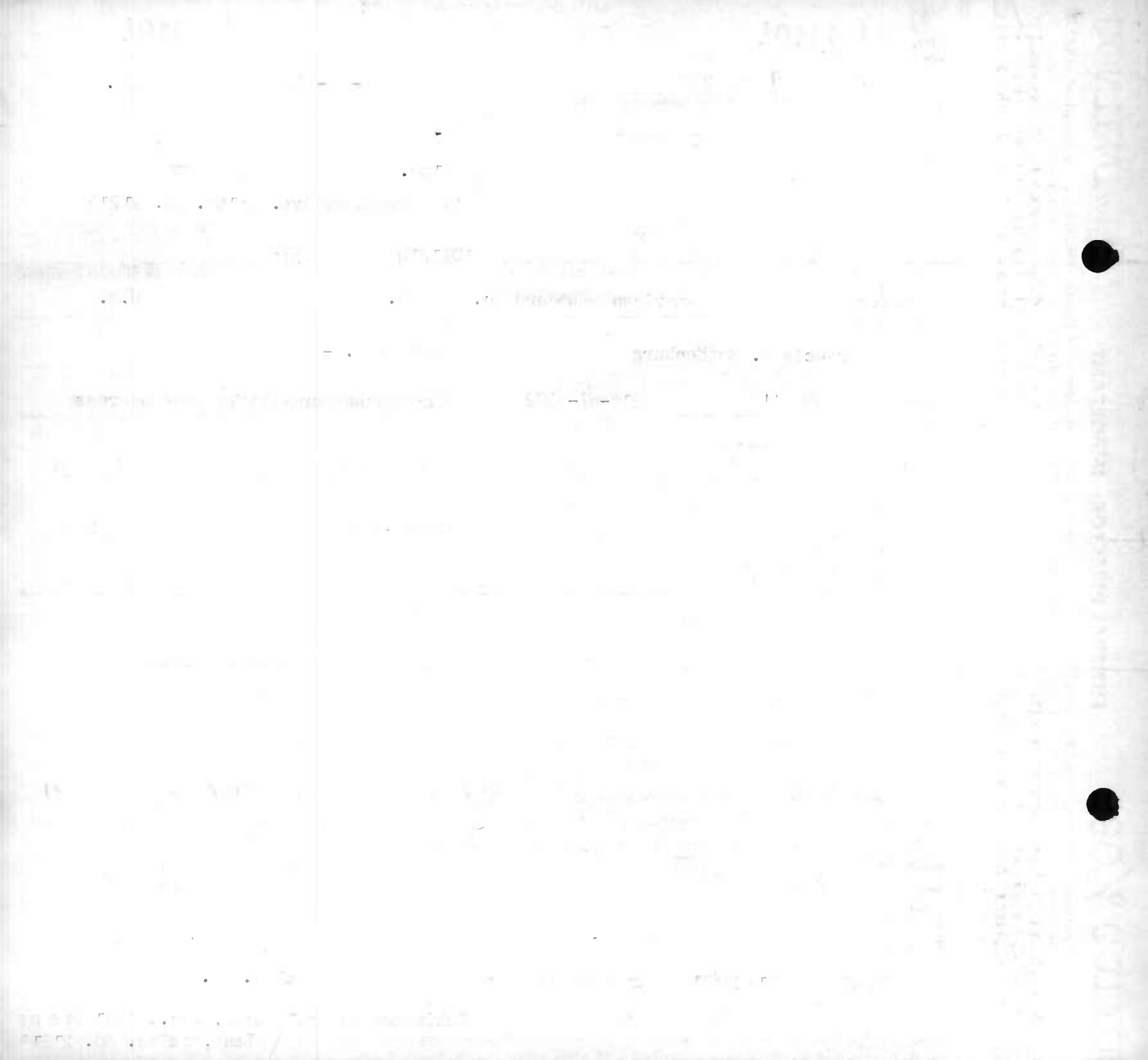
BIRTH NO. 71 11100		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11100	
1. NAME OF DECEASED (Type or Print) JAMES P. MYERS			2. DATE AND HOUR OF DEATH NOV. 27, 1971 5:25 AM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALT. GEN. HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY HOWARD 6300		
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7/27/87 9. AGE (In years last birthday) 84		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Riveter			10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY us		
13. FATHER'S NAME August Myers			14. MOTHER'S MAIDEN NAME Rose Eccleston		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 216-10-11060		
17. INFORMANT Richard Myers (son) same address			ADDRESS		
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CPD			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION 11/25/71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hx pneumonia & gastric ulcer		
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from OCT. 25 1971 to NOV. 27 1971 that (I) (we) last saw the deceased alive on NOV. 27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nelson R. De Lara, M.D.			23B. DATE SIGNED NOV. 27, 1971		
23C. PHYSICIAN'S NAME (Type) NEKSON R. DE LARA, M.D.			23D. ADDRESS SOUTH BALTIMORE GEN. HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/30/71		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971			
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

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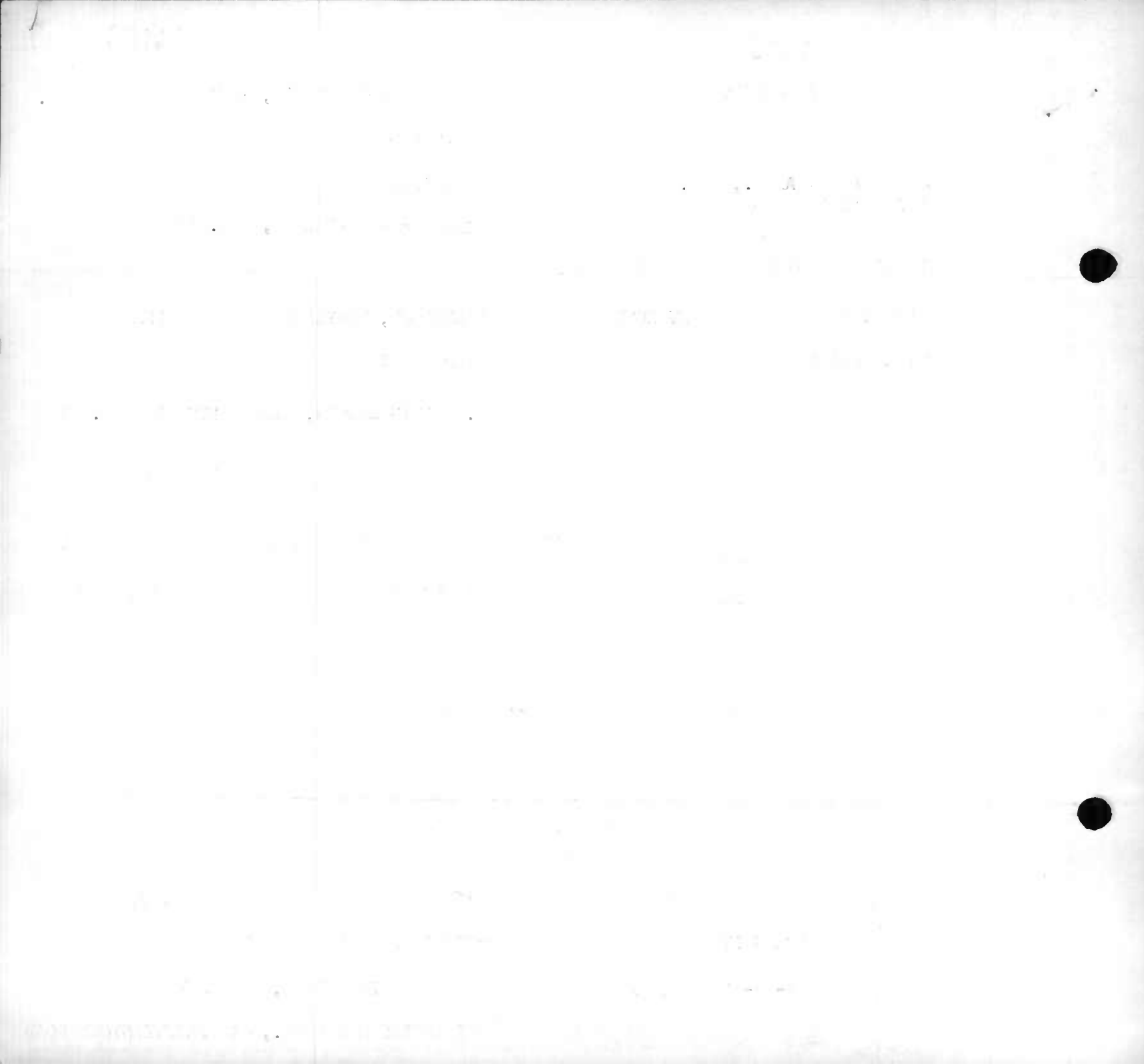
BALTIMORE CITY HEALTH DEPARTMENT				71 11101		71 11101	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JAMES ROTHENBURG				2. DATE AND HOUR OF DEATH 11-26-71 11.00 AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 2633			
5. SEX MALE				6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10/1/14		9. AGE (In years last birthday) 57		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buffer				10B. KIND OF BUSINESS OR INDUSTRY American Standard Co.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Francis A. Rothenburg			
14. MOTHER'S MAIDEN NAME Bertha E. -				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 11			
16. SOCIAL SECURITY NO. 216-07-7302				17. INFORMANT Mary Rothenburg (wife) same address			
18. CAUSE OF DEATH 486X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Ch. lung disease (C) 15x ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days 15x			
19A. DATE OF OPERATION 11/24				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Yes		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 11/24			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 11/26				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 11/26 19 51			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? 11/26 19 51			
22. I certify that (I) (this hospital) attended the deceased from 11/24 to 11/26 19 71 that (I) (we) last saw the deceased alive on 11/26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John OHE				23B. DATE SIGNED Nov. 26, 71		23C. PHYSICIAN'S NAME (Type) John OHE	
23D. ADDRESS Mercy Hospital, Baltimore				23E. DEGREE MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/29/71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc., 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

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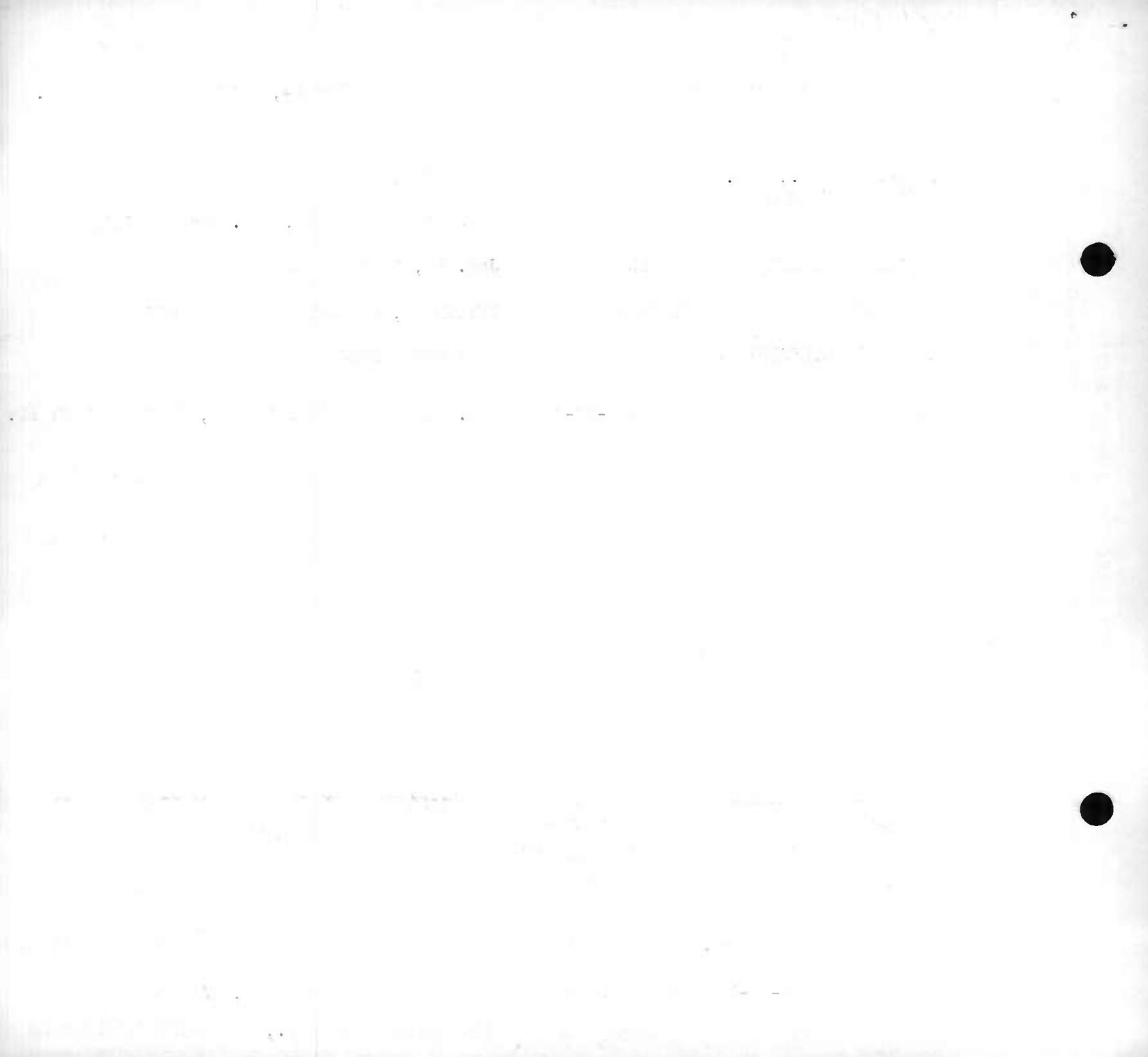
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11102	
BIRTH NO. 71 11102		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA SINGER		2. DATE AND HOUR OF DEATH NOVEMBER 27, 1971 9 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILLOW BROOK APTS., APT. 36 2905 FALLSTAFF ROAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2905 FALLSTAFF ROAD, APT. 36			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 80	9. AGE (In years last birthday) 80	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MORRIS SACHS			
14. MOTHER'S MAIDEN NAME IDA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. MARVIN SINGER, 2108 NORTHCLIFF DR. #21209			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE <u>Carcinoma of Left Kidney</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Heart Dis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Anemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years 1 year					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 11/27/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of L Kidney		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/27/71 to 11/27/71 that (I) (we) last saw the deceased alive on 11/15/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sol Smith		23B. DATE SIGNED 11/27/71		23C. PHYSICIAN'S NAME (Type) SOL SMITH	
23D. ADDRESS 6810 PARK HEIGHTS AVENUE		24A. REMOVAL (Specify) BURIAL			
24B. DATE 11-28-71		24C. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

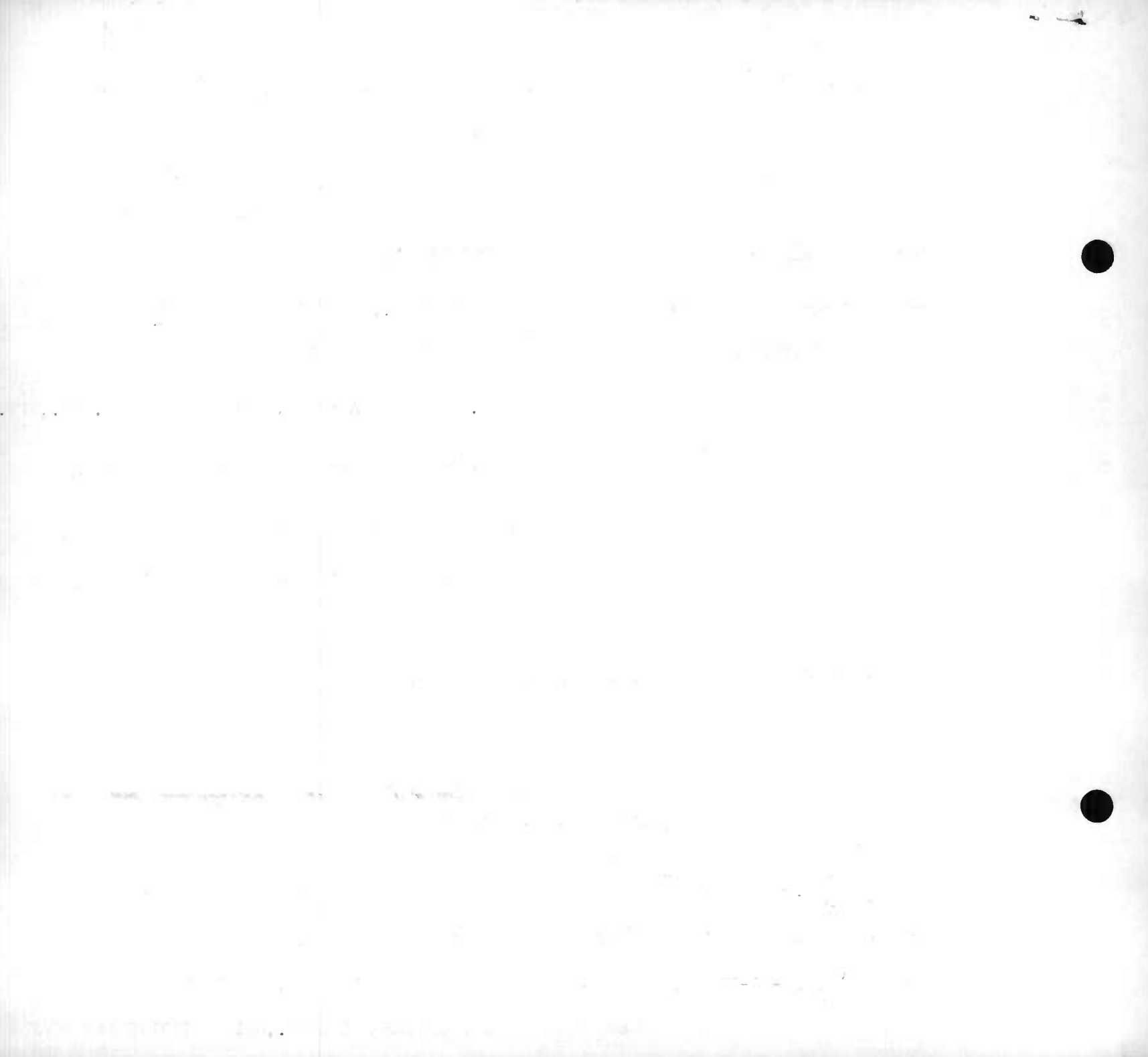
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11103</u>	
BIRTH NO. <u>W409 11103</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>SOPHIE WEIL</u>		2. DATE AND HOUR OF DEATH <u>NOVEMBER 24, 1971</u> <u>11 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>IMPERIAL APTS., APT. 404</u> <u>3601 CLARKS LANE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3601 CLARKS LANE, APT. 404</u> # <u>21215</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1907</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ITTLINGEN, GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ADOLPH EICHTERSHEIMER</u>		14. MOTHER'S MAIDEN NAME <u>JOHANNA LOEB</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>486-20-1682D</u>		17. INFORMANT ADDRESS <u>MRS. MARIANNE WEIL SCHAFER, 3211 BANCROFT RD.</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASHD</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>8 years</u>	
19A. DATE OF OPERATION <u>11/24/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March, 1965</u> to <u>11/24, 1971</u> and that (I) (we) last saw the deceased alive on <u>11/24, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Louis H. Schaffer, M.D.</u>		23B. DATE SIGNED <u>11/24/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Louis H. Schaffer, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-28-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>	
24D. LOCATION (City, town, or county) (State) <u>REISTERSTOWN, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		25D. ADDRESS <u>222 W. Cold Spring Lane, Balto Md 21210</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11104</u>	
<div style="display: flex; justify-content: space-between;"> 13423 11104 B423 11104 </div>					
1. NAME OF DECEASED (Type or Print) <u>ROBERT BLAUSTEIN</u>		2. DATE AND HOUR OF DEATH <u>November 26, 1971 12:44 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL INC.</u> <u>42</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>2720</u>	
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4010 Lafayette Rd.</u>		<u>21215</u>	
5. SEX <u>MALE</u>	6. RACE <input checked="" type="checkbox"/> WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>XXXXXX</u>	9. AGE (in years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SHOES</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>SAMUEL BLAUSTEIN</u>		14. MOTHER'S MAIDEN NAME <u>IDA ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. ARNOLD BLAUSTEIN, 6810 PARK HIGHTS. AVE., APT. T1</u>	
18. <u>53211</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>RENAL INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>4 days</u>	
				(B) <u>CASINO INTESTINAL HEMORRAGE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>1 month</u>	
				(C) <u>DUODENAL ULCER</u> <u>15 years -</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>11/5/1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GI BLEEDING</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 25</u> 19 <u>71</u> to <u>November 26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>November 26</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>11/26/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ERNESTO MAX M.D.</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-28-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>BNAI ISRAEL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>			
25B. NAME OF REGISTRAR <u>Carl E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

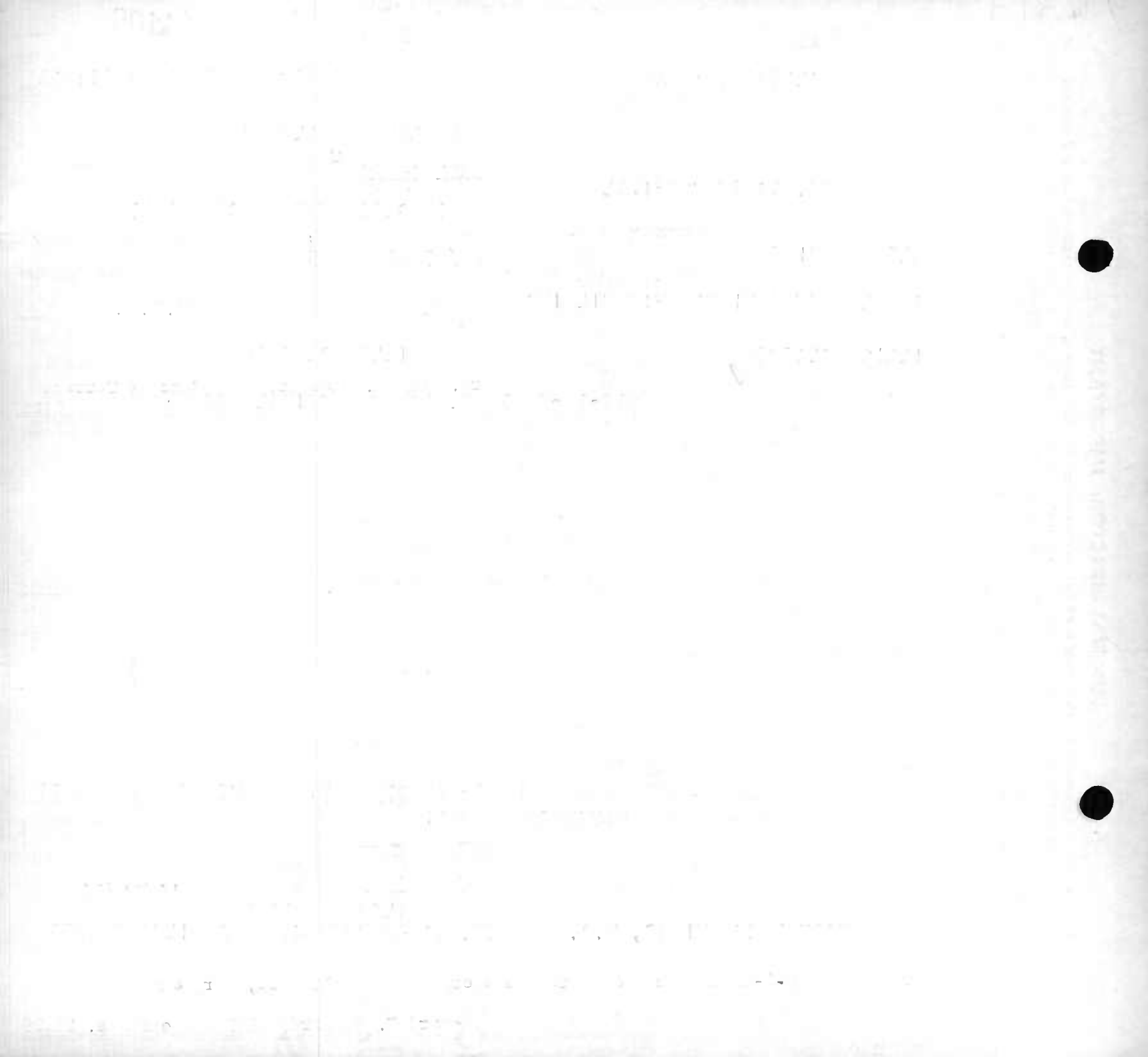
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11105	
BIRTH NO. 71 11105				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SAMUEL KLAPPER			2. DATE AND HOUR OF DEATH 27 NOV 71 0900 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE NEW YORK B. COUNTY Marion C. CITY OR TOWN Randallston INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3616 Temple Rd 295 Wadsworth Ave		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-1895	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME CHAIM DRUCKER			14. MOTHER'S MAIDEN NAME CHATA UDLES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Arlo Klapper - 3616 Temple Rd.	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardio-pulmonary arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HASCD			(B) DUE TO, OR AS A CONSEQUENCE OF: HASCD		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Dissecting Aortic Aneurysm			Acute		
19A. DATE OF OPERATION 17 NOV		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED B K AMPUTATION		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9 NOV 71 to 27 NOV 1971 that (I) (we) last saw the deceased alive on 27 NOV 71 and that (I) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Schultz			23B. DATE SIGNED 27 NOV 71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) SCHULTZ, MICHAEL J. MD			23D. ADDRESS Sinai Hosp. of Balto. Inc.		
24A. BURIAL CREMATION, REMOVAL (Specify) 1/28/71		24B. NAME OF CEMETERY OR CREMATORY Chyik Amuro		24D. LOCATION (City, town, or county) (State) Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Sal Lerman & Sons, 6010 Rust Rd.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 14106	
BIRTH NO. 71 14106		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GLAESER, EDWARD N		2. DATE AND HOUR OF DEATH NOVEMBER 29, 1971 11:05A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO CO			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		C. CITY OR TOWN ARBUTUS		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 4914 GATEWAY TERRACE 21227			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/13	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY SHIPBUILDING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM GLAESER			
14. MOTHER'S MAIDEN NAME MARY MILLER GLAESER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			
16. SOCIAL SECURITY NO. 215-10-5067		17. INFORMANT Mrs. Mary V. Glaeser, 4914 Gateway Terrace ST. AGNES HOSPITAL RECORDS 21227			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary emboli		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cor pulmonale		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) T.B. Pneumonia					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 27 1971 to NOVEMBER 29 1971 that (I) (we) last saw the deceased alive on NOVEMBER 29 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benavides		23B. DATE SIGNED 11/29/71		23C. PHYSICIAN'S NAME (Type) VICTOR BENAVIDES, M.D.	
23D. ADDRESS BALTO, MD 21229		23E. ADDRESS ST. AGNES HOSP; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-2-1971		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION City, town, or county (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

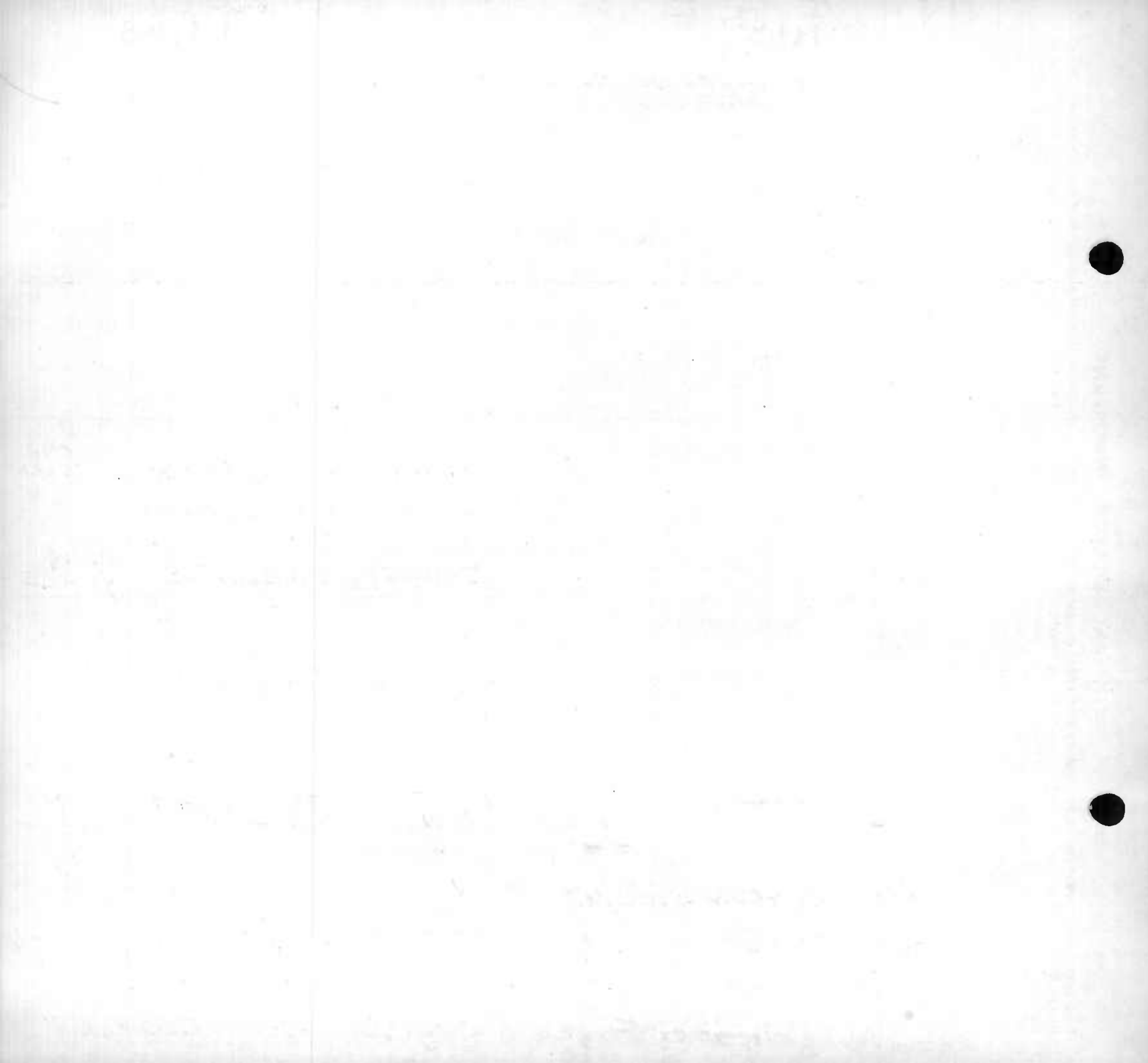
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11107	
BIRTH NO. 71 11107				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Peter E. Fitzsimmons</u>			2. DATE AND HOUR OF DEATH <u>11/26/71</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hosp</u>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2801 N. Calvert St.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/2/1914</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proof Reader</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Publication</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y. N.Y.</u>	
13. FATHER'S NAME <u>Peter J. Fitzsimmons</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Connelly</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>059-03-6488</u>		17. INFORMANT ADDRESS <u>Mrs. Mary E. Fitzsimmons same</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arterio sclerosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>27 Nov 1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF DEATH (Month) (Day) (Year) (Hour) (Approx.) <u>Nov 26 1971</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dead on arrival</u> 19 <u>26 Nov 1971</u> that (I) (we) last saw the deceased alive on <u>Nov 20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>I. Ridgeway Trimble</u>				23B. DATE SIGNED <u>28 Nov 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>I. RIDGEWAY TRIMBLE</u>				23D. ADDRESS <u>6006 Charleswood Road Balto 2122</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/1/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Brooklyn, N.Y.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jarboe, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 5500</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 1 11108	
<div style="display: flex; justify-content: space-between;"> M 63-11108 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY AGNES MEREDITH		NOV. 24, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 4310 LASALLE AVE.			A. STATE M.D. 8. COUNTY 2641		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4310 LASALLE AVE.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 27, 1915	9. AGE (In years lost birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) M.D.	
13. FATHER'S NAME EDWARD W. CLEMON			14. MOTHER'S MAIDEN NAME LILLIE DENN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Henry P. Meredith 4310 Lasalle Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO, OR AS A CONSEQUENCE OF: ACUTE CORONARY THROMBOSIS CORONARY ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: —				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE WEEK MANY YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION —		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 11/15 1971 to 11/24 1971, that (I) lost saw the deceased alive on 11/23 1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE Albert C. Herrmann, M.D.				23B. DATE SIGNED 11/26/71	
23C. PHYSICIAN'S NAME (Type) ALBERT C. HERRMANN, M.D.				23D. ADDRESS 5525 BELAIR ROAD, BALTO. MD 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-24-71		24C. NAME OF CEMETERY or CREMATORY Cathedral Cem.	
24D. LOCATION Baltimore Md.		24E. LOCATION Baltimore Md.		24F. LOCATION Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Taylor-Corcoran & Co., Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

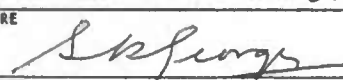
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

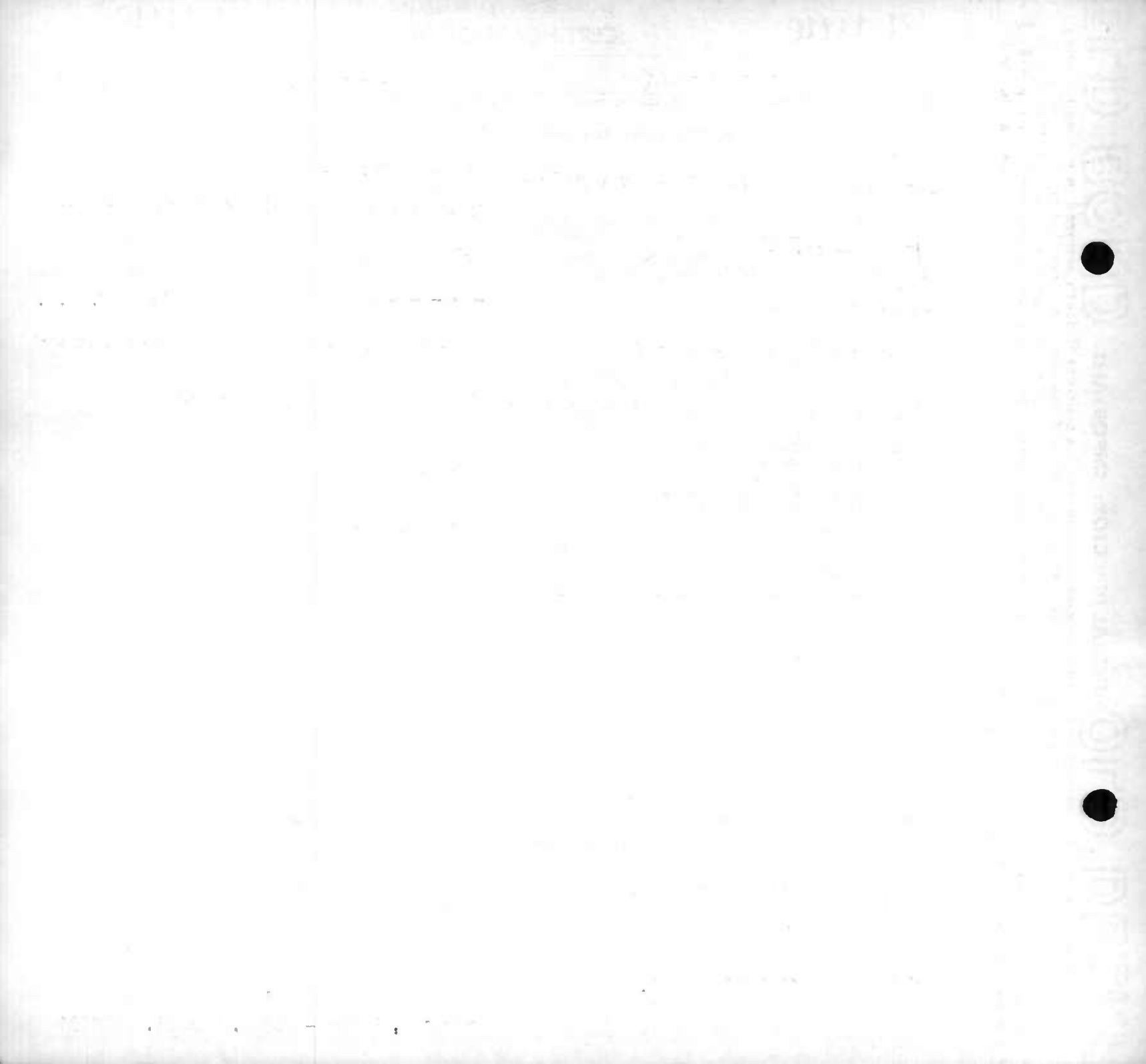
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 294 172	
BIRTH NO. 71 11109				71-11109	
1. NAME OF DECEASED (Type or Print) NARKIEWICZ, JOSEPH PETER				2. DATE AND HOUR OF DEATH 11/27/71 2:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION USPAS HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION BALTIMORE, MD 21211		A. STATE Md.	
				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 427 S. Bonsal St.	
5. SEX M	6. RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/1927	9. AGE (In years last birthday) 44	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) S/Sgt Ret.		10B. KIND OF BUSINESS OR INDUSTRY Military		11. BIRTHPLACE (State or foreign country) PA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JACOB NARKIEWICZ		14. MOTHER'S MAIDEN NAME Helen ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 204 18 1790		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE CARDIORESPIRATORY FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Occlusion of coronary artery (B) DUE TO, OR AS A CONSEQUENCE OF: Severe generalized atherosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal Recent chronic vascular disease	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert R. Wright, M.D.				23B. DATE SIGNED 11/28/71	
23C. PHYSICIAN'S NAME (Type) ROBERT R. WRIGHT, M.D.				23D. ADDRESS USPAS Hosp. BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-1-71		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary Cemetery	
				24D. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11110	
BIRTH NO. 71 11110				1. NAME OF DECEASED (Type or Print) SOPHIA PASUK		2. DATE AND HOUR OF DEATH 11-29-71 10-15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 105			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35				E. STREET AND NUMBER 218 S. COLLINGTON AVE. #21231			
5. SEX F	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-1902	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER			11. BIRTHPLACE (State or foreign country) ALBERTA Alabama		12. CITIZEN OF WHAT COUNTRY? AMER. U. S.A.		
13. FATHER'S NAME MARTIN HULAK			14. MOTHER'S MAIDEN NAME CATHERINE WAGONA WYCONNY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-14-4556		17. INFORMANT ADDRESS RAYMOND PASUK, same		
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASYSTOLE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 220 M. J. CHF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minutes long duration			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (the) (this hospital) attended the deceased from 11-11-1971 to 11-29-1971 that (we) (we) last saw the deceased alive on 11-29-1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED 11-29-71		23C. PHYSICIAN'S NAME (Type) S. P. GEORGE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/2/71		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Farley, MD		25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St.		ADDRESS #21231	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Catherine Steele		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 11 29 711 1:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 29 71 1:40 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug. 23, 1904		10. AGE (In years last birthday) 66	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		14B. KIND OF BUSINESS OR INDUSTRY Crown, Cork & Seal Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-07-9884	
18. INFORMANT Jerome Peters - 1617 Mussula Road #21204		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 11-30-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/71	
24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231		ADDRESS	

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TO THE DIRECTOR, BUREAU OF RESEARCH

FROM THE DIRECTOR, BUREAU OF RESEARCH

RE: [illegible]

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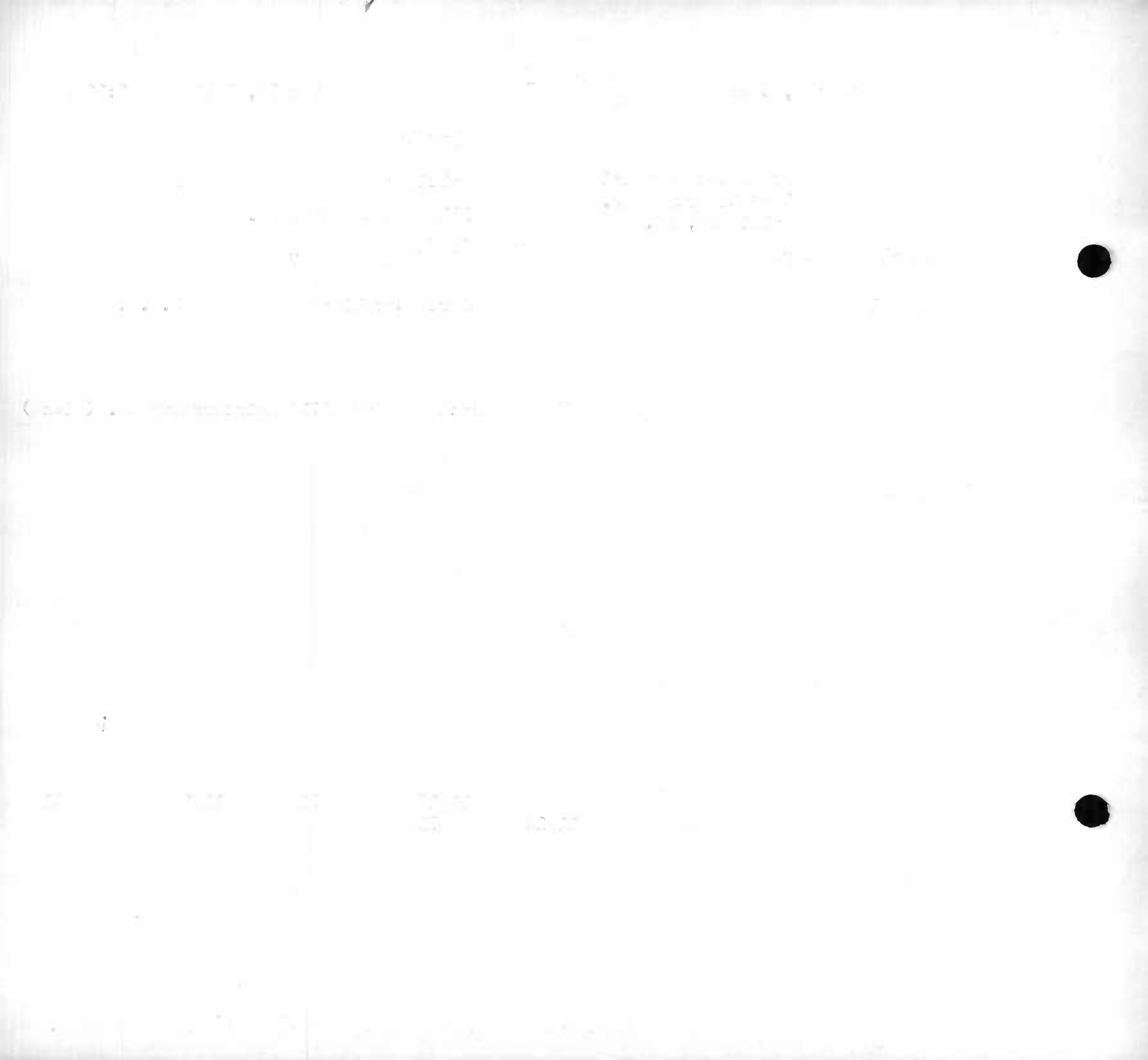
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11112</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>71 11112</u>					
1. NAME OF DECEASED (Type or Print) <u>Simmons, Cora</u> (<u>Cora Simrirel - Simrel</u>)		2. DATE AND HOUR OF DEATH <u>November 26, 1971</u> <u>2:22 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital</u> <u>2600 Liberty Hgts.</u> <u>Baltimore, Md.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1512</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3726 Reisterstown Rd.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/1884</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Sam Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Ida</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <u>XXX</u>		16. SOCIAL SECURITY NO. <u>240-92-0561</u>		17. INFORMANT <u>Grace Sheppard 3726 Reisterstown Rd. (niece)</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Severe Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>Electrolyte Imbalance</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>Renal Failure</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Decubitus ulcer</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH [Indify medical examined]		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> 19 <u>71</u> to <u>11/26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/26</u> 19 <u>71</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Desiderio L. Hebron, Jr.</u>		23B. DATE SIGNED <u>11/29/71</u>		23C. PHYSICIAN'S NAME (Type) <u>DESIDERIO L. HEBRON, JR.</u>	
23D. ADDRESS <u>2600 Liberty Heights</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/3/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Johnsville Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Sykesville, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Kenneth H. Law</u>	
25D. ADDRESS <u>4611 Park Hgts.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

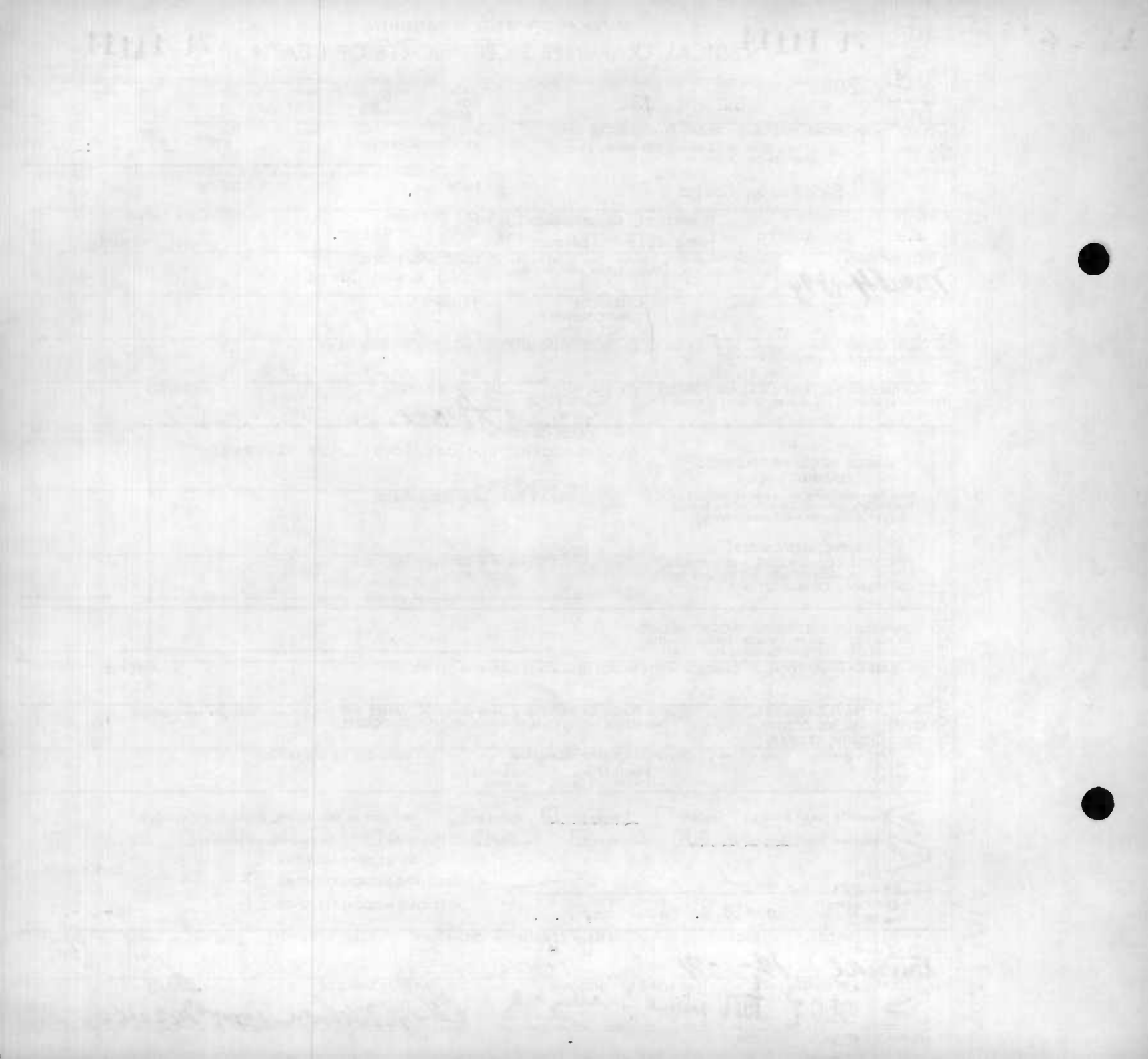
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11113</u>	
BIRTH NO. <u>71 11113</u>					
1. NAME OF DECEASED (Type or Print) <u>James Wesley Anderson</u>		2. DATE AND HOUR OF DEATH <u>Nov. 28, 1971</u> <u>3:10 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1702</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>male</u> 6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/24/02</u> 9. AGE (in years last birthday) <u>68</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>	
13. FATHER'S NAME <u>James Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Anderson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-01-6242</u>		17. INFORMANT <u>Mrs. Anderson</u> ADDRESS <u>same</u>	
18. <u>2309 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
		(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>25 yrs.</u>	
		(C) <u>Diabetes mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Carcinoma of Sigmoid Colon</u>				<u>7</u>	
19A. DATE OF OPERATION <u>11/10/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Transverse Colostomy</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 8</u> 19 <u>71</u> to <u>Nov. 28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>November 28</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Laurence Blumberg, M.D.</u>				23B. DATE SIGNED <u>11/28/71</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-2-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Nottingham Cmt</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>E. & Wilson</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) WILLIAM COLLIER		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 345 Mason Court		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour	M.
				11	27	1971	6:30 p	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 361		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						
9. DATE OF BIRTH March 4-1894		10. AGE (In years last birthday) 77		11. BIRTHPLACE (State or foreign country) South Carolina				
		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unknown				
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME unknown				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 119-02-2159		18. INFORMANT Louise Gray 1417 Oakland St				
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
		(B) DUE TO, OR AS A CONSEQUENCE OF:						
		(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-28-71				
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-2-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Cent		24D. LOCATION (City, town, or county) (State) White Md		
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS Elroy Wilson 1000 Chantilly Dr				



W-650

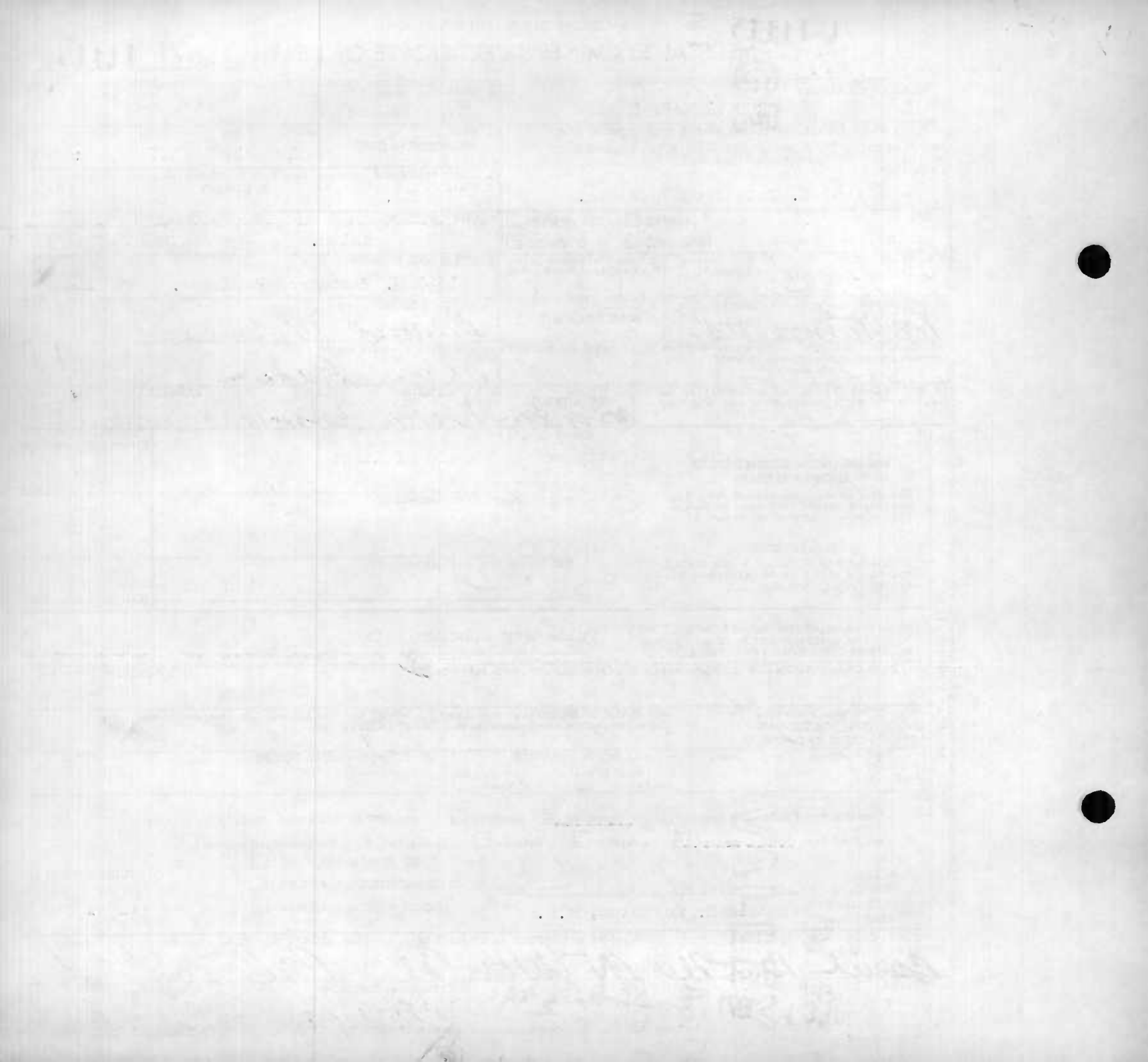
71 11115

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11115

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROBERT WARREN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1647 N. Patterson Park Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 27 1971 11:05 a.m.		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 802	
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 8-27-1923		10. AGE (in years lost birthday) 48		E. STREET AND NUMBER 1647 N. Patterson Park Ave. 2nd floor	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Warren	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Lizzie Parker	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 25-44-8493		18. ADDRESS Wells Rose 1623 Ingram Rd	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary tuberculosis					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-28-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-2-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cmt	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Ed. Wilson, 1000 Broadway		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>71 11116</u>	
BIRTH NO. <u>71 11116</u>		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>ALBERT POLLARD</u>				2. DATE AND HOUR OF DEATH <u>11/28/71</u> <u>1:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>561</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1204 SHORT COURT</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-10-08</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALBERT POLLARD SR.</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE MILLER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-6274</u>		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH <u>Pneumonia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory failure</u> (B) <u>Squamous cell carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: <u>lung.</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> 19 <u>71</u> to <u>11/28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. Hollenberg D.Phil.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/28/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. HOLLENBERG</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-4-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. Calvary Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Johnny O. W. Linn 1000 Broadway Ave</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11117</u>	
BIRTH NO. <u>71 11117</u>		1. NAME OF DECEASED (Type or Print) <u>Samuel Fields</u>		2. DATE AND HOUR OF DEATH <u>11-27-71</u> <u>6:00 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lincoln Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1402</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lincoln Nursing Home</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>700 Mosier St</u>					
5. SEX <u>M</u>	6. RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1921</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>Samuel Fields</u>			14. MOTHER'S MAIDEN NAME <u>Julia Bolden</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-22-4314</u>		17. INFORMANT <u>William Fields</u> ADDRESS	
18. <u>593.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD & myocar</u> <u>dial insufficiency</u> (B) <u>CVA rt side</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Renal Insufficiency</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-19-1971</u> to <u>11-27-1971</u> that (I) (we) last saw the deceased alive on <u>11-27-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. I. Baykaler M.D.</u>				23B. DATE SIGNED <u>11-27-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. I. BAYKALER M.D.</u>			23D. ADDRESS <u>301 Mc Mechen St. Balto, Md.</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-4-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn A.C. Club</u>	
24D. LOCATION (City, town, or county) (State) <u>South Carolina</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Shirley O. Wilson</u> ADDRESS <u>1000 Bunting Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
71 11118					71 11118				
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print) <u>JOSEPH BOSTON</u>					2. DATE AND HOUR OF DEATH <u>11/29/71</u> <u>12:25 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u> <u>48</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO. CITY</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1118 STRICKER ST</u>				
5. SEX <u>M</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/9/39</u>	9. AGE (in years last birthday) <u>32</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13. FATHER'S NAME <u>George Boston</u>					14. MOTHER'S MAIDEN NAME <u>Emma Curtis</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Fannie Green-1520 Bruce St.</u>				
18. <u>53101</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY DEATH</u> DUE TO, OR AS A CONSEQUENCE OF: <u>2.0 MIN</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <u>HEMORRHAGE 2° TO GI BLEEDING</u> DUE TO, OR AS A CONSEQUENCE OF:				
					(C) <u>GASTRIC ULCER & GASTRITIS</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHRONIC ALCOHOLISM, PANCREATITIS, HEPATIC COMA</u>									
19A. DATE OF OPERATION <u>11/29/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GI BLEEDING (GASTRIC ULCER)</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>C</u>		21C. WHERE DID INJURY OCCUR? <u>C</u>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>0</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>C</u>					
22. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 15, 1971</u> to <u>NOVEMBER 29, 1971</u> that (I) (we) last saw the deceased alive on <u>NOVEMBER 29, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Phillip E. Middleton</u> DEGREE					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>11/29/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>PHILLIP E. MIDDLETON</u> DEGREE					23D. ADDRESS <u>UNIV. OF MD. HOSP BALTO., MD</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-3-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Sabin, M.D.</u>			25C. FUNERAL DIRECTOR <u>Y. BAILEY</u> ADDRESS <u>Kelson F. H. 1348 Colborn St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 11119		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11119	
1. NAME OF DECEASED (Type or Print) Hattie Davis			2. DATE AND HOUR OF DEATH 11-30-71 11:20 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lincoln Memorial Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 1802		
5. SEX F			6. RACE Negroid		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 4-18-1900 9. AGE (In years last birthday) 71
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Davis			14. MOTHER'S MAIDEN NAME Liza Thomas		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 577-50-3967		17. INFORMANT Maggie Freeman ADDRESS 622 Baker St.
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertension ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA Pemphigus Vulgaris			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 9-17-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-17-68 to 11-30-71 that (I) (we) last saw the deceased alive on 11-29-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. L. Baykaler, M.D.			23B. DATE SIGNED 11-30-71		23C. PHYSICIAN'S NAME (Type) A. L. BAYKALER, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12-3-71		24C. NAME OF CEMETERY or CREMATORY t. Auburn Cem.
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971			25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H., 1348 Calhoun Street

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11120

71 11120

BIRTH NO. 71 11120		2. DATE AND HOUR OF DEATH November 28, 1971 7:30 AM	
1. NAME OF DECEASED (Type or Print) Antoinina Lombardo		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 113 S. Conkling Street		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 113 S. Conkling Street	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/1877
9. AGE (In years lost birthday) 94		If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Vincenzo Ficuccia		14. MOTHER'S MAIDEN NAME Rosa	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Margaret Camponeschi		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Cancer of Breast & Metastasis</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 65 to 11/28/71 19 71 , that (I) (we) last saw the deceased alive on 11/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Joseph R. Liberto M.D.</i>		23B. DATE SIGNED 11/30/71	
23C. PHYSICIAN'S NAME (Type) J.R. LIBERTO, M.D.		23D. ADDRESS 3508 BANK ST. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/1/71	24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Joseph N. Zannino		ADDRESS 263 S. Conkling St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 11121	
71 11121		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Carnes, Harry Lee		Nov. 23, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00			A. STATE Maryland B. COUNTY 2608		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3402 Mt. Pleasant Avenue			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3402 Mt. Pleasant Avenue		
5. SEX M	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/84	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Standard Oil		10B. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ananias Carnes		14. MOTHER'S MAIDEN NAME Eleanor Miles	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 216-10-4340		17. INFORMANT Mr. Carnes, son	
18. 712.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebro-Vascular accident - Sudden DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardio DUE TO, OR AS A CONSEQUENCE OF: Vascular disease 5 yrs (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-2-1970 to 11-23-1971, that (I) (we) last saw the deceased alive on 11-22-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George Baumgardner		23B. DATE SIGNED 11/24/71		23C. PHYSICIAN'S NAME (Type) George Baumgardner, M. D.	
23D. ADDRESS 8552 Philadelphia Road, Balto 21237		23E. ATTENDING PHYSICIAN Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/26/71		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Baltimore, Maryland		24E. STATE m		24F. CITY, TOWN, OR COUNTY	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. FUNERAL DIRECTOR Joseph N. Zannino, 263 S. Conkling Street	

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This body released to Woodside Mem. Chaple, 58 th St. Queens N.Y.

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 11122			
BIRTH NO. 71 11122											
1. NAME OF DECEASED (Type or Print) JOSEPH MURPHY						2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL						3. DATE PRONOUNCED DEAD Month Day Year Hour 11 28 1971 11:25 P.					
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE New York B. COUNTY V29											
6. SEX male		7. RACE white		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN 21p 11377 Woodside, Queens			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH July 9, 1902			10. AGE (in years lost birthday) 69		11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 5915 47th Ave.		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mailer						15. MOTHER'S MAIDEN NAME Katherine Hennessy					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no						17. SOCIAL SECURITY NO. 056 03 8966		18. INFORMANT ADDRESS 59-15 47th Ave, Hannah Murphy Woodside, Queens, N.Y. 11377			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) no											
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-29-71											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12/2/71		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cem.			24D. LOCATION (City, town, or county) (State) Brooklyn, N.Y.			
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971			25B. NAME OF REGISTRAR Robert E. Farber, R.D.			25C. FUNERAL DIRECTOR Higinbotham Slack			ADDRESS Ellicott City, Md. 21043		

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11123

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MICHAEL TAYLOR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 28 1971 12:20 PM	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO C. CITY OR TOWN Hydes D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
9. DATE OF BIRTH 4/12/47		10. AGE (in years last birthday) 24	E. STREET AND NUMBER Box 106 Harford Rd.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Walter C. Taylor
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail order clerk		14B. KIND OF BUSINESS OR INDUSTRY News-American	15. MOTHER'S MAIDEN NAME Anne E. Wheatley
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4/66 to 2/3/70		17. SOCIAL SECURITY NO. 220-52-3442	18. INFORMANT ADDRESS Hydes, Md. 21082 Walter C. Taylor-Box 106, Harford Rd.
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 11-28-71 7 a m.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Harford Rd.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in auto that struck a utility pole.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-29-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/2/71	
24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Bel Air Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home Inc. 6009 Harford Rd. - Balto., Md. 21214		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 111241	
71 111241				71 111241	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAMS, KATIE (Johnson)		11/28/71 10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
33 JOHNS HOPKINS			Maryland 1002		
5. SEX			6. DATE OF BIRTH		9. AGE (In years last birthday)
Female			2/22/06		65
7. RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. IF Under 1 Yr. Months Days
Negro			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife			—		N. Carolina
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lee Strickland			Hepsie Cogdol		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			220-18-4956		Delores Griffin-1713 E. Oliver St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
410.91			MYOCARDIAL INFARCT		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/26 1971 to 11/28 1971 that (I) (we) last saw the deceased alive on 11/28 1971 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Edward Feinglass M.D.				11/28	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Edward Feinglass, M.D.				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-4-71		Mt. Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 1 1971		Robert E. Faber, R.D.		ELLIOTT Funeral Home 1129 N. Caroline St.	



W160

71 11125

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11125

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN WEAVER

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1248 Gay St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

11

29

1971

2 a

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md.

B. COUNTY

808

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1-6-41

10. AGE (In years
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1807 Henneman Ave

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Allen Weaver

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Construction Worker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Minor Youngblood

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

217-18-1784

18. INFORMANT

Barbara Whitworth - 1807 Henneman Ave

ADDRESS

19.

E970X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Gunshot wound of head

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1248 Gay St.

22D. TIME
OF INJURY
(APPROX.)

11-29-71

1:45a m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subj. shot by police during robbery

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-29-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-4-71

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION

(City, town, or county)

(State)

A.A. County, Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 1 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Elliott Funeral Home - 1129 N. Caroline St.



2 525
M 400

71 11126

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11126
REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Elizabeth Johnson (Mull)

2. DATE
OF
DEATH

Known ☐
Estimated ☒

Month
Day

Year

Hour

11

29

71

11:40 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1811 E. Biddle Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

11

29

71

11:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

808

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

9. DATE OF BIRTH

7-9-17

10. AGE (In years
lost birthday)

354

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1811 E. Biddle Street - 21213

11. BIRTHPLACE (State or foreign country)

N. Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Skellie Harrington

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Wife

14B. KIND OF BUSINESS OR INDUSTRY

Hospital

15. MOTHER'S MAIDEN NAME

Julia Still

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL
SECURITY NO.

18. INFORMANT

Delores Holt Malby - 2605 Muratt

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED
WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Deputy CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-30-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-4-71

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State)

P. A. County, Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 1 1971

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Elbert Funeral Home 1129 N. Calvert St.

ADDRESS

1111

1111

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 11127		71 11127	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
CAROLYN H. FITZGERALD				DEC. 1, 71 1 3 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
				MARYLAND		2711	
C. CITY OR TOWN				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER	
UNION MEMORIAL HOSPITAL				100 W. COLD SPRING LANE			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
F	WW	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/3/1895		76		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOMEMAKER			OWN HOME		MARYLAND		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM HUMPHREYS				MARGARET HUNGERFORD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
No			—		MR. LYNN C. FITZGERALD		SAME
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 11/23/71 to 12/1/71 and that (I) (we) last saw the deceased alive on 12/1/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
[Signature]				12-1-1971			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CESAR VILUARAN INTERN				33rd and Calvert St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-3-71		Druid Ridge Cemetery		Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 1 1971		Robert E. Taylor, M.D.		H. W. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212	

1961-1962

1961-1962

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1961-1962

1961-1962

1961-1962

1961-1962

1961-1962

1961-1962

1961-1962

1961-1962

1961-1962

1961-1962

1961-1962

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 11128		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 11128 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JONES, MRS. Lizzie (Elizabeth)</u>		2. DATE AND HOUR OF DEATH <u>11/29/71</u> <u>6:50 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1301</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2401 Eutaw Place</u>					
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01/01/1909</u>	9. AGE (in years last birthday) <u>62</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>?</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Admission Sheet</u>			
18. <u>4-12-41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>none</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Shock + Anemia</u> (B) <u>Renal Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (C) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>N/A</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20A. AUTOPSY (Yes or No) <u>N/A</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u>		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) <u>N/A</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>N/A</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR <u>N/A</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>11-26</u> 19 <u>71</u> to <u>11-29</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11-29</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Lopez</u>		23B. DATE SIGNED <u>11-29-71</u>		23C. PHYSICIAN'S NAME (Type) <u>GERARDO M. Lopez</u>	
23D. ADDRESS <u>Bon Secours Hospital</u>		23E. FUNERAL DIRECTOR <u>Morlan - 11</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-2-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>	
24D. LOCATION <u>Balto, Md</u>		24E. FUNERAL DIRECTOR <u>Morlan - 11</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morlan - 11</u>	
25D. ADDRESS <u>1701 - Lawrence St</u>					

9/15/71

No Prev. Address given

F 640

71 11129

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11129
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) H. Columbus Ferrell Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 29 71 5:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 29 71 5:45 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH July 11, 1934		10. AGE (In years lost birthday) 37	
11. BIRTHPLACE (State or foreign country) Balto, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Marie Hall	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 215-30-9724	
18. INFORMANT Mrs. Marie Murray		ADDRESS 5319 Liberty Hgts.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Stab wound of temple DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME OF INJURY (APPROX.) 11 23 71 5:00 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 612 Collette Avenue 1501		22F. HOW DID INJURY OCCUR? stabbed during argument	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 1, 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11130

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Glenn Williams aka James Cole

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Lutheran Hospital 5/8/72

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

6. SEX

male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

2/7/52

10. AGE (In years
last birthday)

19

11. Under 1 Yr. 12 Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

615 Linnard Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

Glen Williams, Sr

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Agusta Agusta

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs Judith Williams, 4002 Hilton Rd

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Gunshot wound of abdomen

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIBUTING
☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

HOME

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

615 Linnard Street

22D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) 11 25 71 11:55 a.m.22E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject shot during altercation.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/26/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/2/71

24C. NAME of CEMETERY or CREMATORY

M⁺ Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

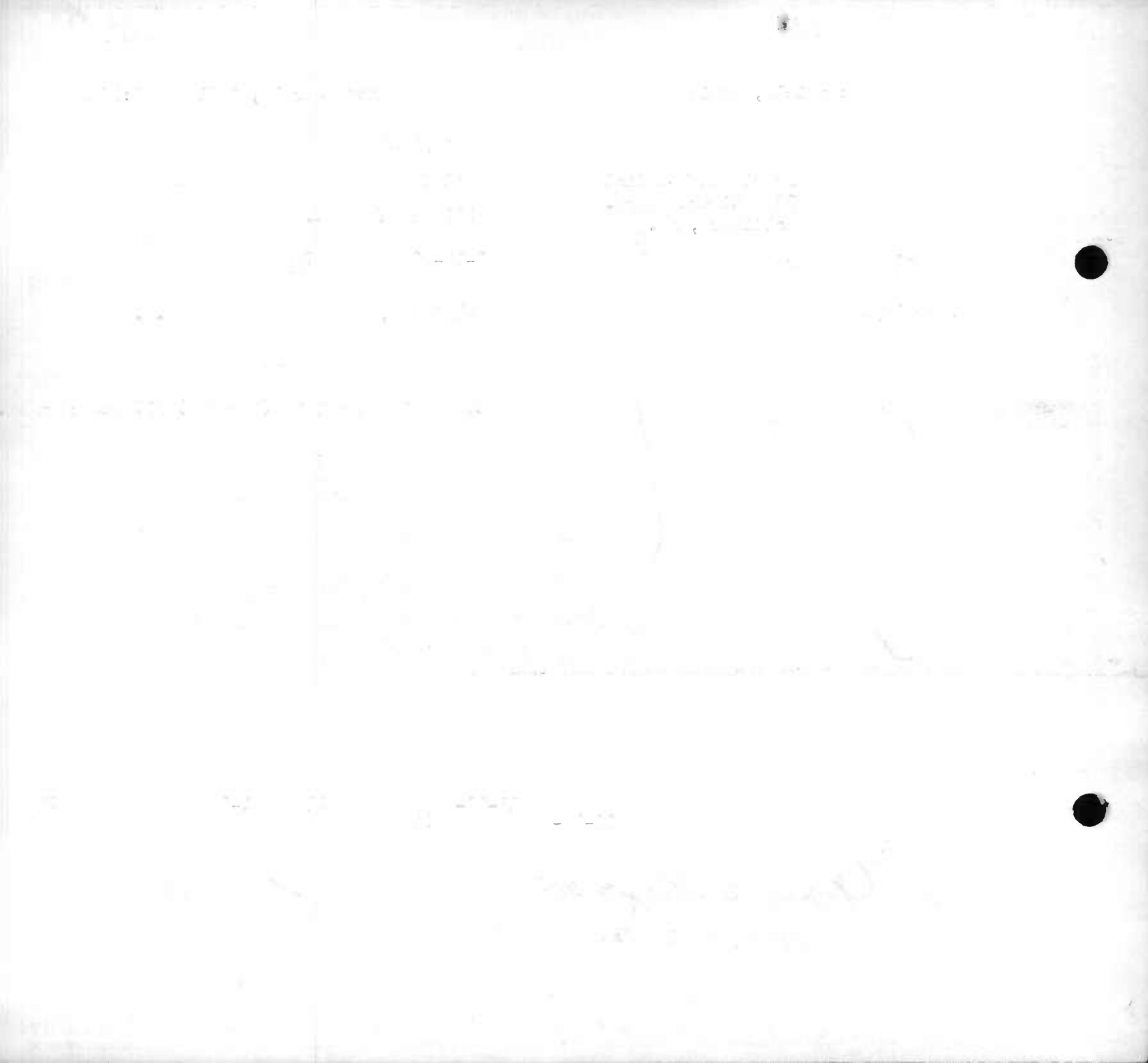
Adolphus Halstead 1206 W North Av

Newspaper clipping from Afro American 11/26/71 to show that Glen Williams used the name of James Cole. SMN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11131	
BIRTH NO. 71 11131					
1. NAME OF DECEASED (Type or Print) McDaniels, Annie		2. DATE AND HOUR OF DEATH November 29, 1971 8:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1402			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 2600 Liberty Hosp. Baltimore, Md.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2-12-00	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) Baltimore, Md		9. AGE (in years last birthday) 71	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT Campfield McDaniels (husband)		ADDRESS 537 McMechen St.			
18. 533.91 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Upper G-I Bleeding, Massive					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Peptic Ulcer of Stomach					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Subtotal - Gastrectomy					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ① Collapse/consolidation ② Coll		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-21 19 71 to 11-29 19 71 that (I) (we) last saw the deceased alive on 11-29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gregorio J. Tengco M.D.				23B. DATE SIGNED 12/1/71	
23C. PHYSICIAN'S NAME (Type) Gregorio J. TENGCO M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/71		24C. NAME of CEMETERY or CREMATORY MT Auburn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR Adolphus Halstead	
				ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

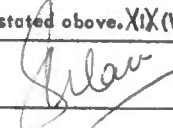
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

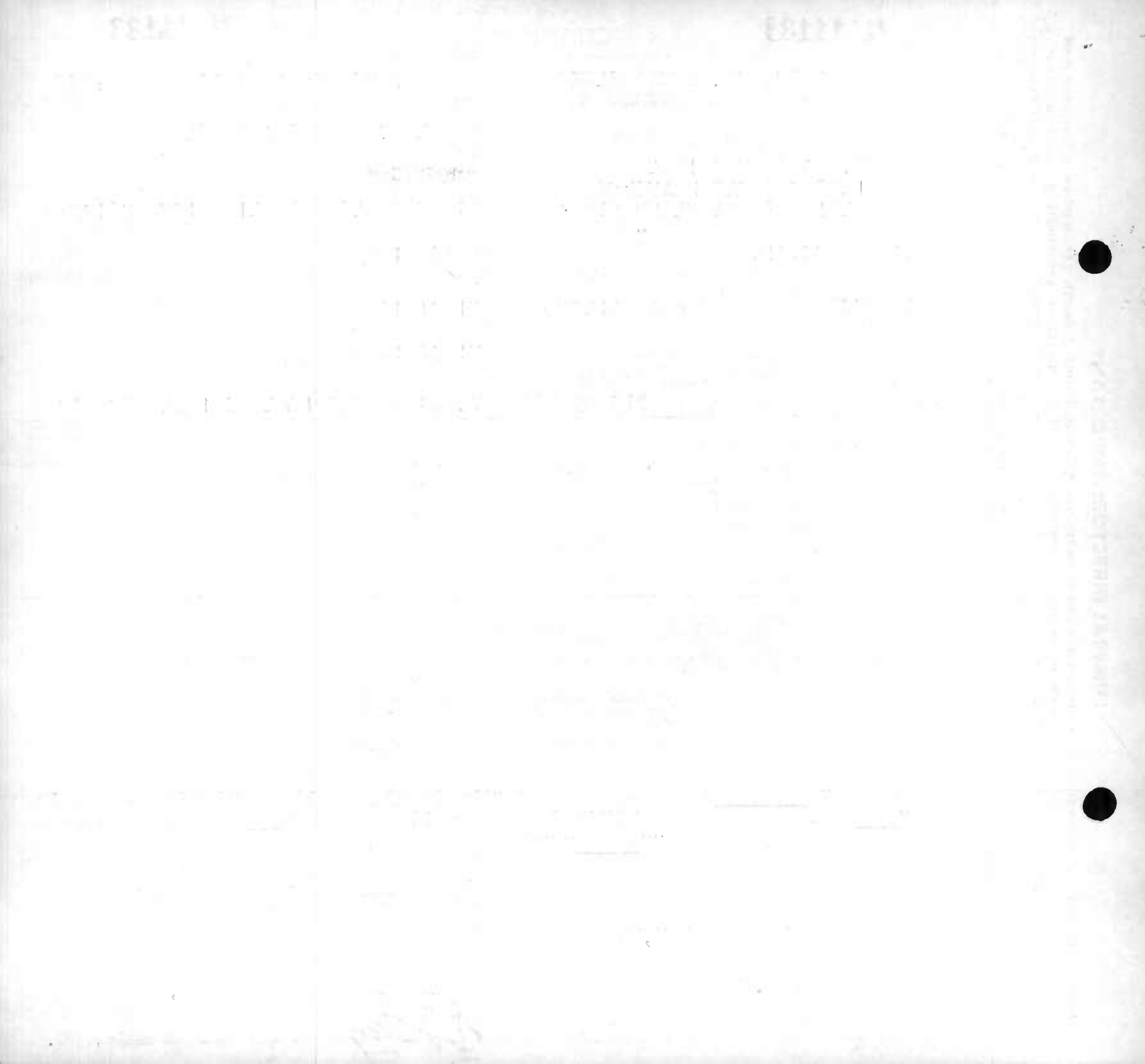
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 11132	
BIRTH NO. 71 11132		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>JOHNSON FANNIE G.</u>		2. DATE AND HOUR OF DEATH <u>11/22/71</u> <u>930</u> P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>TALBOT</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>OXFORD</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-20-04</u>	
9. AGE (in years last birthday) <u>67</u>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>EDWARD GIBSON</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA CHASE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>145-16-1009</u>		17. INFORMANT <u>James H. Johnson</u> ADDRESS: <u>Tilghman Street Oxford, Maryland</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CARCINOMA OF CERVIX</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:				<u>2 yrs</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>NOV 9</u> 19 <u>71</u> to <u>NOV 22</u> 19 <u>71</u> and that (1) (we) lost saw the deceased alive on <u>8:30pm Nov 22 19 71</u> and that (1) (my) (own) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (not) view the body after death.							
23A. SIGNATURE <u>T. J. Harrigan M.D.</u>		23B. DATE SIGNED <u>11/22/71</u>		23C. PHYSICIAN'S NAME (Type) <u>T. J. HARRIGAN, M.D.</u>			
23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>		23E. DEGREE <u>DEGREE</u>		23F. ATTENDING PHYSICIAN Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/27/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Streamerville</u>		24D. LOCATION (City, town, or county) (State) <u>Oxford, Talbot Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>J.B. Dashiell</u>		25D. ADDRESS <u>P.O. Box 606 Eastern, Md. 21661</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11133	
BIRTH NO. 71 11133		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BOOTH, SR. OSCAR ELMER		2. DATE AND HOUR OF DEATH NOVEMBER 29 1971		8:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229		A. STATE MARYLAND		B. COUNTY ANNE ARUNDEL	
C. CITY OR TOWN LINTHICUM		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 310 OAKDALE ROAD LINTHICUM HEIGHTS		21090			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 26 91	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONDUCTOR		10B. KIND OF BUSINESS OR INDUSTRY B & A RAILROAD		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME NICODEMUS BOOTH			
14. MOTHER'S MAIDEN NAME VIRGINIA KESSLER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215 09 4648		17. INFORMANT ADDRESS ST. AGNES HOSPITAL MEDICAL RECORDS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Cardio-pulmonary Arrest. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Arrest. (B) DUE TO, OR AS A CONSEQUENCE OF: Atrial fibrillation. (C) Urinary & Hypertension.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 27 19 71 to NOVEMBER 29 19 71 that (X) (we) last saw the deceased alive on NOVEMBER 29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 11/29/71		23C. PHYSICIAN'S NAME (Type) SUROOR ALAM, MD	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE DEC. 2/71		24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN MEMORIAL PARK		24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR SINGLETON FUNERAL HOME GLEN BURNIE, MD.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. **71 11134**

BIRTH NO. 71 11134		1. NAME OF DECEASED (Type or Print) Francis Franklin Dunn		2. DATE AND HOUR OF DEATH November 28, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2201			
FULL NAME OF HOSPITAL OR INSTITUTION Melchor Nursing Home 2327 N. Charles Street		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/18/1904		9. AGE (in years last birthday) 67		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Woodlawn, Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Frank Dunn		14. MOTHER'S MAIDEN NAME Elizabeth (Schriver)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 220-05-1679 A		17. INFORMANT 9122 Liberty Road Mr and Mrs. Ernest Greenwalt 21133	
18. 410-9-1 250-9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Myocardial Infarction (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Diabetes Mellitus (C) Several years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few minutes			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 4 19 71 to Nov 28 19 71 that (I) (we) last saw the deceased alive on Nov. 26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Low Zimmerman M.D.		23B. DATE SIGNED 11/28/71		23C. PHYSICIAN'S NAME (Type) Low Zimmerman	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/71		24C. NAME of CEMETERY or CREMATORY Mount Olive Cemetery	
24D. LOCATION Randallstown, Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Loring Byers		25D. ADDRESS 8728 Liberty Rd. Randallstown, Md.			

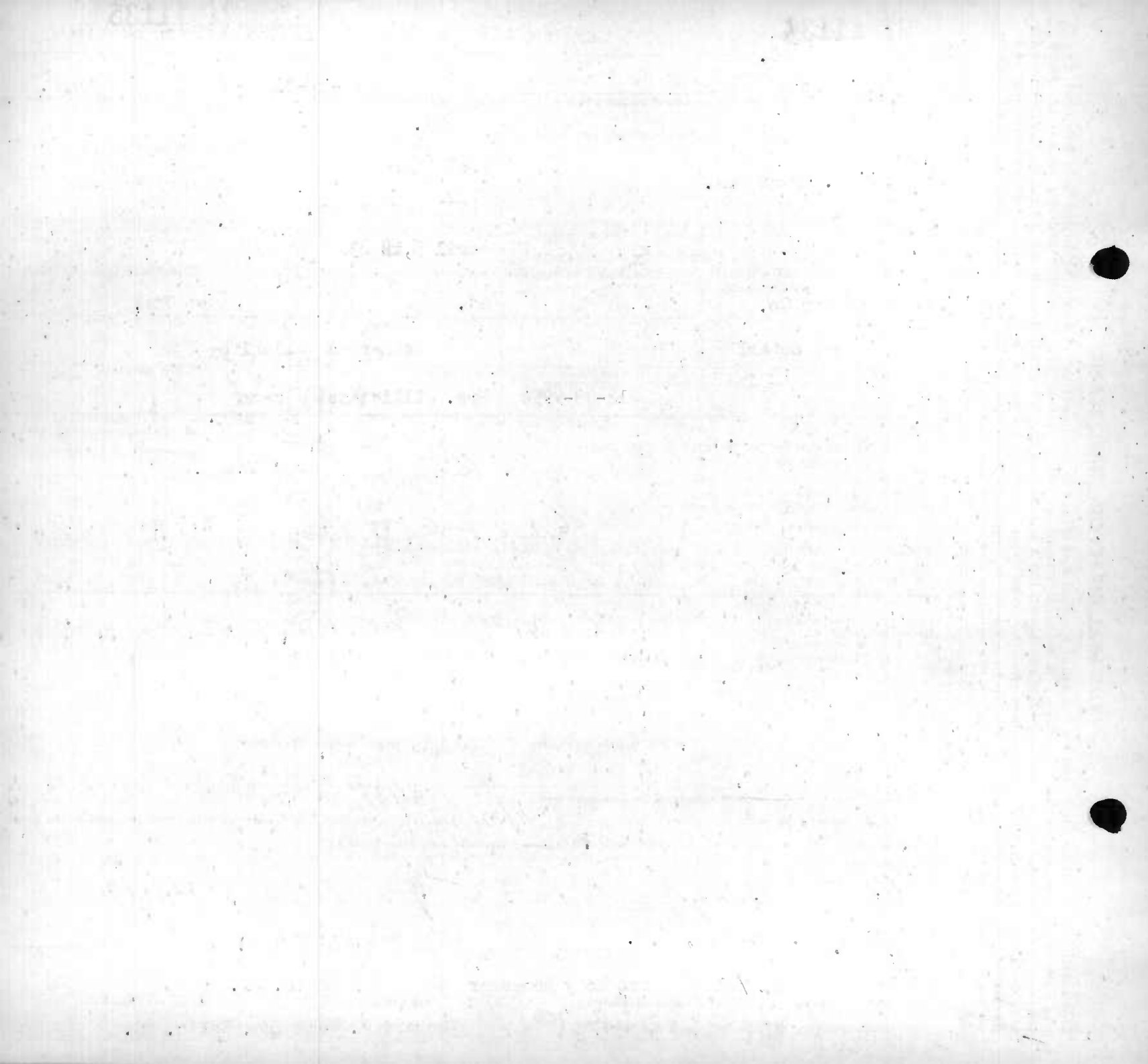
522 S. Hanover.

Adm. 11/3/71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11135	
71 11135				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Scharf		11-30-71 6 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 4211 RayMar Ave.			Md. 2632		
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M.		W.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
April 5, 19 83		88		USA.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
American Can Co.			Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frank Scharf			Catherine Milchling		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		212-03-9998		Mrs. Billie Kost same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from 6/13/1967 to 11/30/1971, that (I) (we) last saw the deceased alive on 11/27/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Albert B. Bradley, M.D.				12/1/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Albert B. Bradley, M.D.				4900 Belair Road 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/3/71		Most Holy Redeemer	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 2 1971		Robert E. Fisher, M.D.		Leonard J. Ruck Inc. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H 300 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 11136

BIRTH NO.

71 11136

1. NAME OF DECEASED
(Type or Print)

REESE HADDAWAY

2. DATE AND HOUR OF DEATH

11/30/71

3:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL OF BALTIMORE

42

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

903

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3620 KIMBLE RD

5. SEX

Male

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

11/26/88

9. AGE (in years
last birthday)

82

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

Baltimore Transit Co

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hugh A Haddaway

14. MOTHER'S MAIDEN NAME

Martha L Lednum

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-10-0469

17. INFORMANT

Mrs Elizabeth Haddaway

ADDRESS

Same

18. I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARCINOMA OF COLON

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 11/18/71 to 11/30/71
that (1) (we) last saw the deceased alive on 11/30/71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

B. KERZNER MD

DEGREE

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

11/30/71

23C. PHYSICIAN'S
NAME (Type)

B. KERZNER MD

DEGREE

23D. ADDRESS

SINAI HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

12/3/71

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

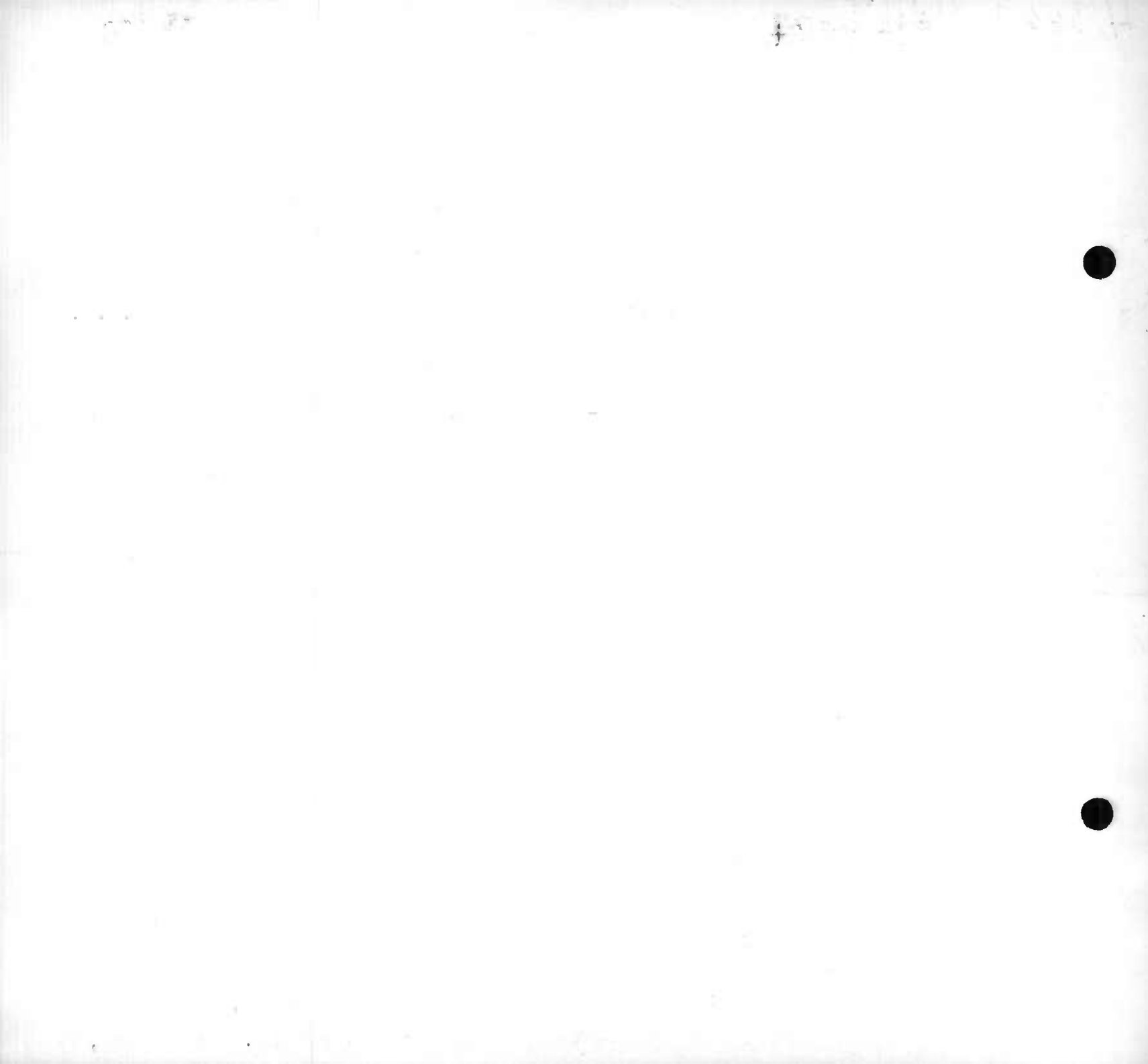
25C. FUNERAL DIRECTOR

ADDRESS

DEC 2 1971

Robert E. Fisher, MD

Leonard J. Ruck Inc. Baltimore, Md



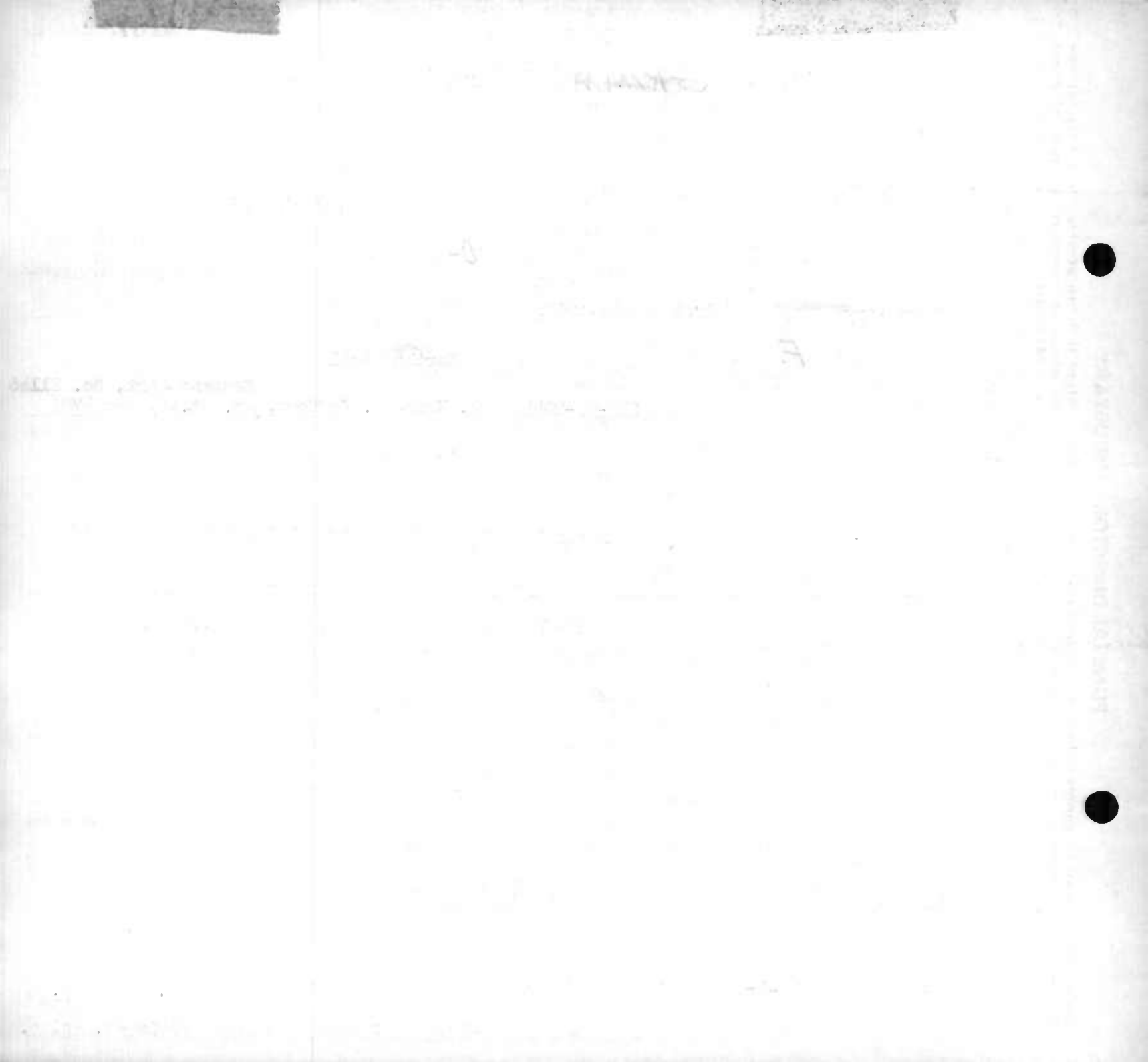
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 11137

BIRTH NO. 11137		1. NAME OF DECEASED (Type or Print) BERTHA GRIMM JEFFERS		2. DATE AND HOUR OF DEATH 11/30/71 9:08 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4 UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 1206		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 4 UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2715 N. CHARLES ST.		5. SEX FEMALE		6. RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-15-92		9. AGE (In years last birthday) 79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HENRY F. GRIMM		14. MOTHER'S MAIDEN NAME Bertha Feil	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-2044		17. INFORMANT Col. Henry A. Jeffers, Jr. Rt. 2, Box 470A	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CONGESTIVE HEART FAILURE (TRIC. FIBRATION)		CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: (B) CEREBRO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: (C) 2 DAYS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/28 19 71 to 11/30 19 71 that (I) (we) last saw the deceased alive on 11/30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ramon Del Busto MD		DEGREE		23B. DATE SIGNED 11/30/71	
23C. PHYSICIAN'S NAME (Type) RAMON DEL BUSTO MD		DEGREE		23D. ADDRESS UNION MEMORIAL Hosp. BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-3-71		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Parkville Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Rd. Balto.		21236	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 11138		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11138	
1. NAME OF DECEASED (Type or Print) <u>TELLI'S MARIE V.</u>			2. DATE AND HOUR OF DEATH <u>30 Nov 1971</u> <u>10⁵⁵</u> P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV. OF MARYLAND, UNIVERSITY HOSP.</u> <u>Baltimore Md</u>			A. STATE <u>MARYLAND</u> , B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1312 JAMES ST. 3303 PARK LAWN AVE</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/03</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Shoe Store</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>William Thompson</u>			14. MOTHER'S MAIDEN NAME <u>Mary Lewis</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Mary Provenson</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hepatorenal Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>7/23</u> 19 <u>71</u> to <u>11/30</u> 19 <u>71</u> that <u>(X)</u> (we) last saw the deceased alive on <u>11/30</u> 19 <u>71</u> and that <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>R. A. Rashti MD</u>			23B. DATE SIGNED <u>11/30/71</u>		23C. PHYSICIAN'S NAME (Type) <u>R. A. Rashti</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>12/4/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Conway & Son, Inc. 901 Hollins St. Balt. Md 21223</u>



71 11139

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11139

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CURTIS HORTON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Garage - rear of 1611 Church St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

11

28

1971

5:15

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE

Md.

B. COUNTY

2505

6. SEX

male

7. RACE

white

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7-7-20

10. AGE (In years
last birthday)

51

11. Under 1 Yr. 11 Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1611 Church St.

11. BIRTHPLACE (State or foreign country)

TENN.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph HORTON

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BRICKLAYER

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

SHANKS

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes W.W.II 10-19-42-46

17. SOCIAL
SECURITY NO.

26-18-4638

18. INFORMANT

WIFE

ADDRESS

1611 Church ST.

19.

E9821X

CAUSE OF DEATH

Carbon monoxide poisoning

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

garage

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

rear 1611 Church St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

11-28-71

?

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Undetermined - found in garage

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-29-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12-1-71

24C. NAME OF CEMETERY or CREMATORY

CEDAR HILL

24D. LOCATION (City, town, or county) (State)

RITCHIE HWY. BALTO. M.D.

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

HAHN FUNERAL Home 4200 PENNINGTON

ADDRESS

11132

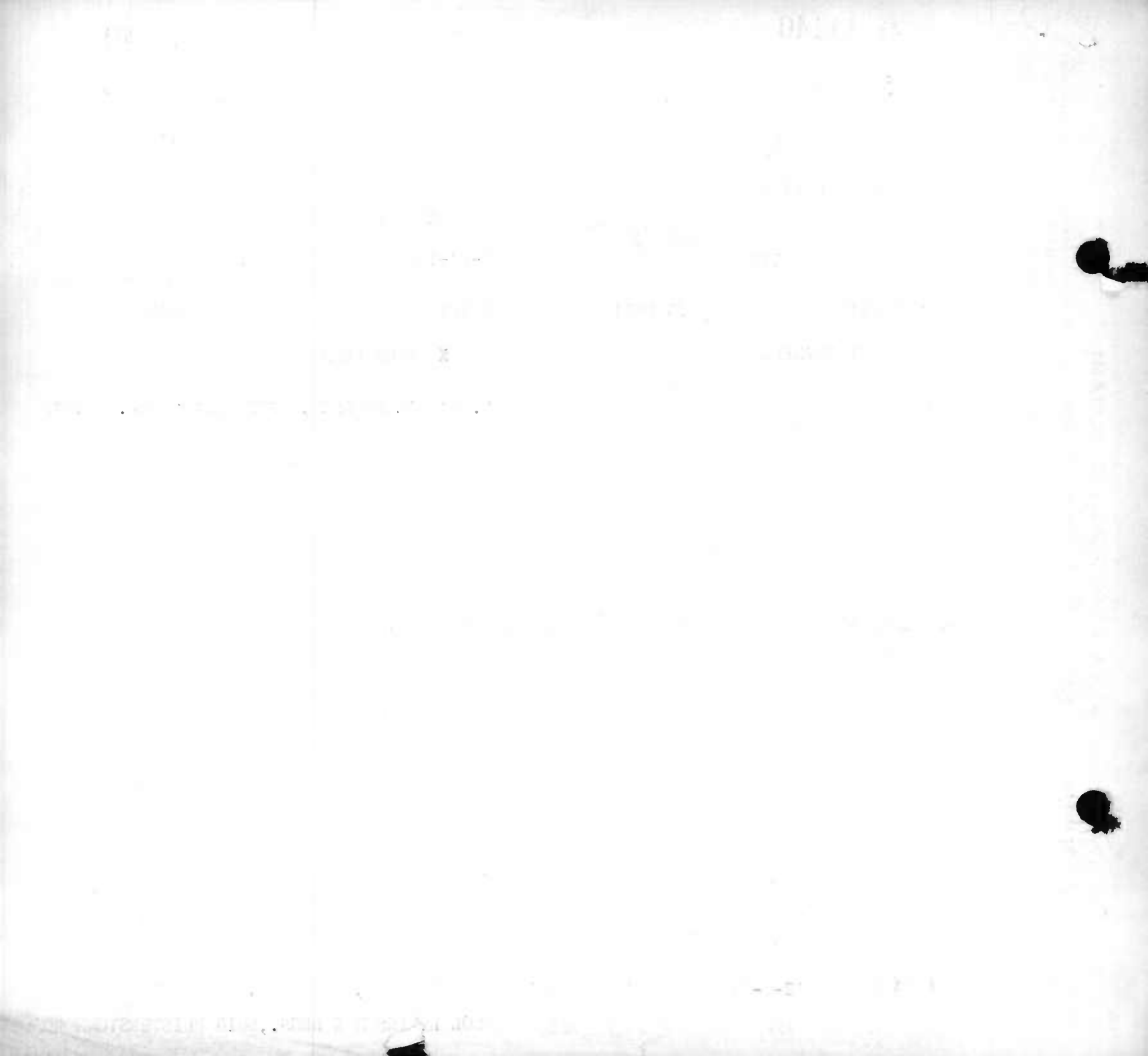
11132

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S542

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11140	
BIRTH NO. 71 11140					
1. NAME OF DECEASED (Type or Print) SMOLKIN, Rose		2. DATE AND HOUR OF DEATH 11/29/71 - 11:07 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2788			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5323 NELSON AVENUE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1886	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME HERSCHEL FRANKEL		14. MOTHER'S MAIDEN NAME FAGA RENA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. SAMUEL SMOLKIN, 5323 NELSON AVE. #21215	
18. 410.9 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASHD.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 wks.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes - septicemia					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1950 to present 19____ that (1) (we) last saw the deceased alive on 11/29 19 71 and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard Burgin M.D.		23B. DATE SIGNED 11/29/71			
23C. PHYSICIAN'S NAME (Type) BERNARD BURGIN		23D. ADDRESS 3809 Clarke Lane Balto			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-1-71		24C. NAME of CEMETERY or CREMATORY OH R KNESSETH ISRAEL ANSHE SFARD, ROSEDALE, MARYLAND	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11141

REG. NO. 71 11141

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Jerome Katz

2. DATE
OF DEATHKnown ☒ Estimated ☐Month
11Day
30Year
71Hour
8:25 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

Sinai Hospital

3. DATE
PRONOUNCED DEADMonth
11Day
30Year
71Hour
8:25 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2719

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

APRIL 11, 1932

10. AGE (In years
last birthday)

39

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

5817 Narcissus Avenue

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

MAX KATZ

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

COUNTERMAN

14B. KIND OF BUSINESS OR INDUSTRY

UPTOWN DELICATESSEN

15. MOTHER'S MAIDEN NAME

YETTA FOX

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

KORENA WAR

17. SOCIAL
SECURITY NO.

220-34-5767

18. INFORMANT

ADDRESS

MR. MAX KATZ, 5817 NARCISSUS AVE. #21215

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Narcotic addiction
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-30-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12-1-1971

24C. NAME OF CEMETERY or CREMATORY

SWINICHER WOLINER BENEVOLENT, BALTIMORE, MARYLAND

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 2 1971

1971

Robert E. Taylor, M.D.

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

1111

1111

APRIL 11, 1951

BALTIMORE, MARYLAND

JOHN F. BURNETT

1111

[Handwritten signature]

BALTIMORE, MARYLAND

1111

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **71 11142**

BIRTH NO.

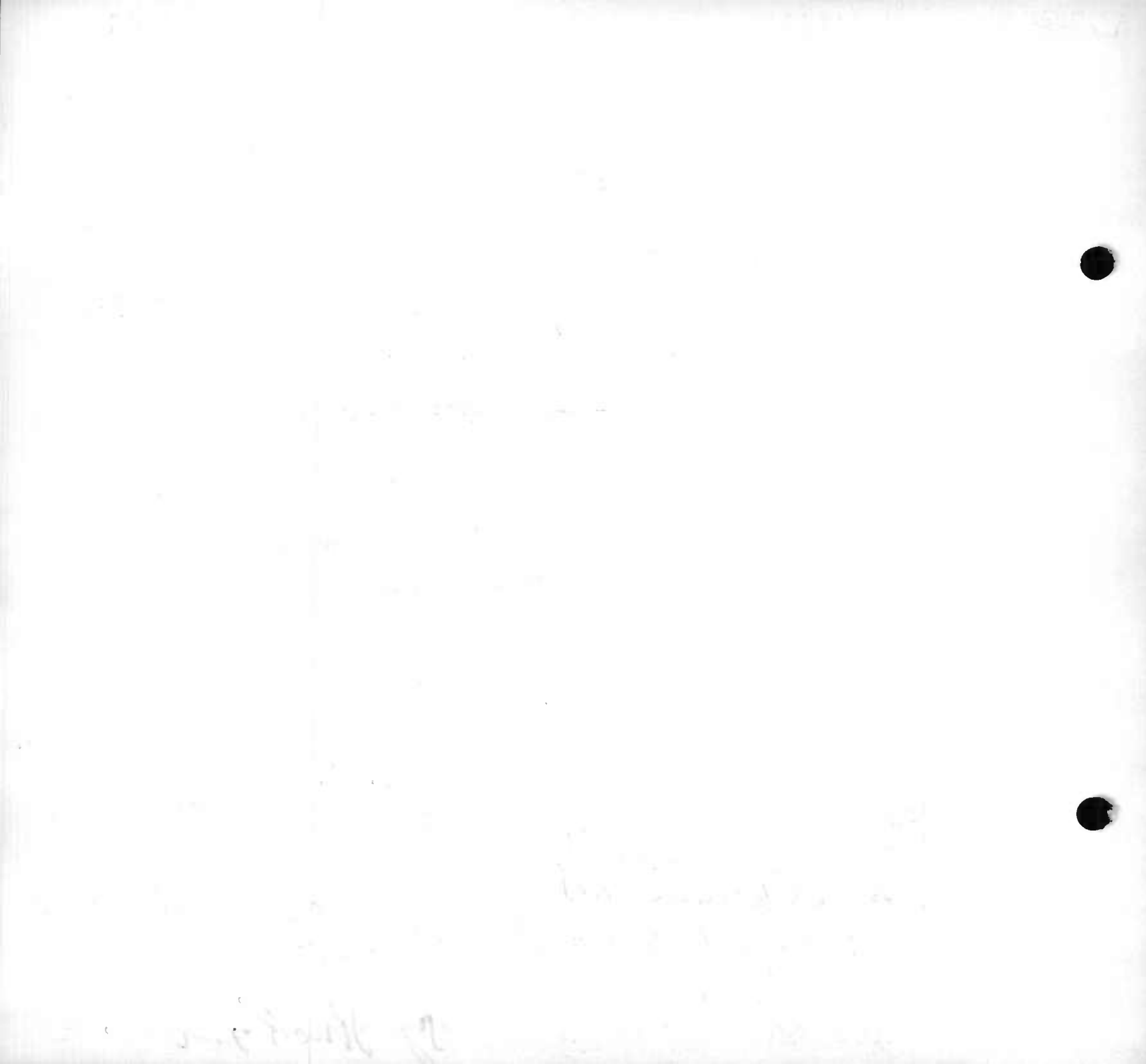
1. NAME OF DECEASED (Type or Print) BARBARA E. YOCUM				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 611 Park Avenue Apt. 409				3. DATE PRONOUNCED DEAD Month Day Year Hour 11 27 1971 12:45 a M.			
6. SEX female				7. RACE white		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 3-13-1932				10. AGE (In years last birthday) 39		C. CITY OR TOWN Balto.	
11. BIRTHPLACE (State or foreign country) New Jersey				12. CITIZEN OF WHAT COUNTRY? U.S.A.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				14B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER 611 Park Avenue Apt. 409	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 266-40-3712		13. FATHER'S NAME Romayne T. Uhler	
18. INFORMANT James R. Eyler, Esq., 10 Light St.				15. MOTHER'S MAIDEN NAME Hilde Bresser		ADDRESS	
19. E-984, X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Drowning DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 611 Park Ave. Apt. 409	
22D. TIME OF INJURY (APPROX.) Nov. 1971 ? m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found in bathtub	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		11-27-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11-30-71		24C. NAME OF CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd		ADDRESS	

Letter from M.E.'s office 12-16-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

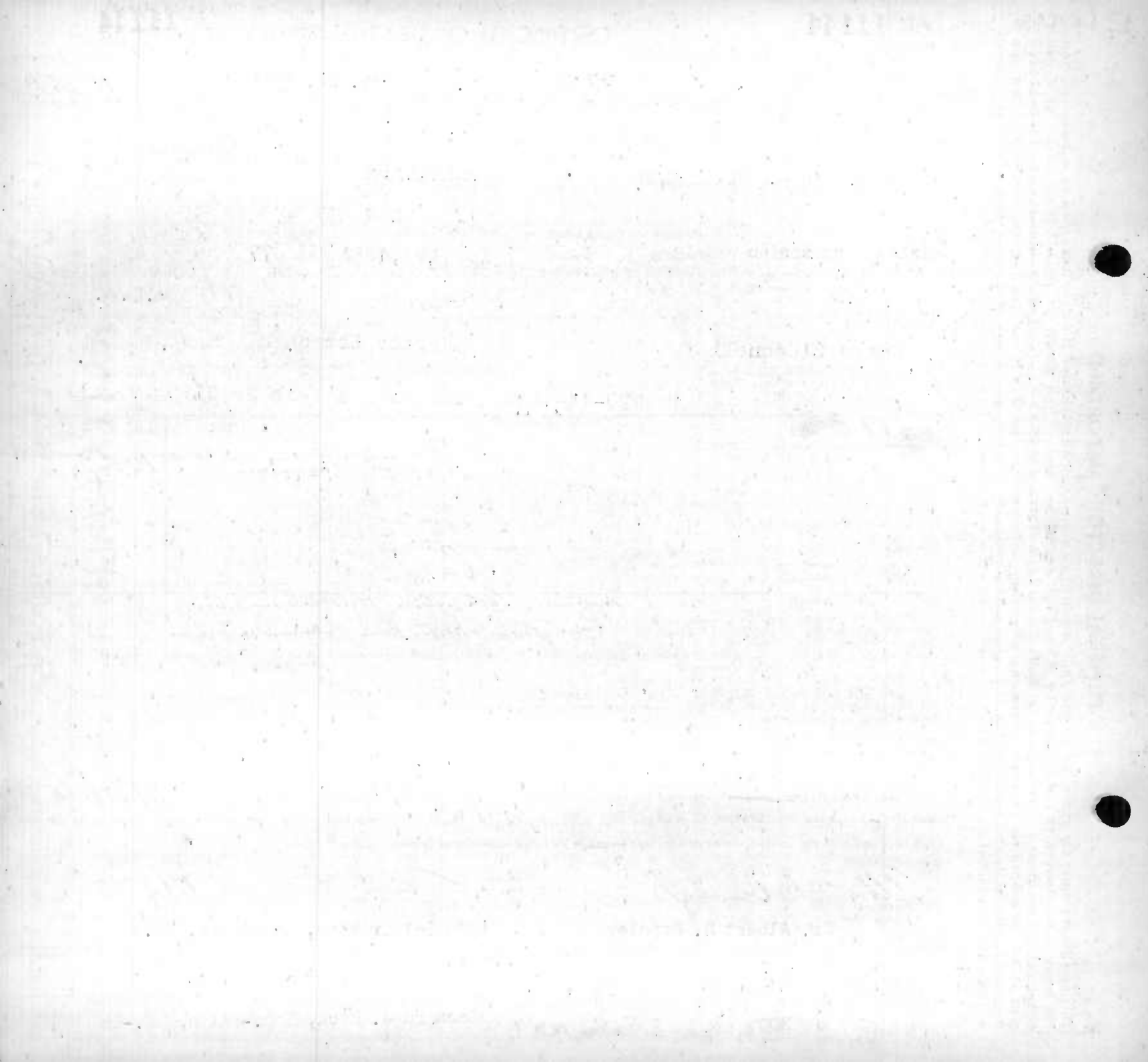
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11143
BIRTH NO. 71 11143		1. NAME OF DECEASED (Type or Print) Mrs. Blanche ^E Boughter		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 11/28/71 11:47 A.M.		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL Hospital 48		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY CITY BALTO 5300		
		C. CITY OR TOWN Balt.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 7800 Wintenhaven Rd		
5. SEX F	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/06	9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Sophronia ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-3716		17. INFORMANT Charles Mr Galbert E Boughter ADDRESS Same
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ruptured aneurysm				
(B) DUE TO, OR AS A CONSEQUENCE OF: ASD. Aneurysm				
(C) ASCVD				
MEDICAL CERTIFICATION				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21D. TIME OF INJURY (APPROX.)		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11/26 1971 to 11/28 1971 that (I) (we) last saw the deceased alive on 11/26 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE George E. Hannon M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/28/71
23C. PHYSICIAN'S NAME (Type) ROBERT C. SOMMERS M.D.		23D. ADDRESS 1107 N. M. A. H.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/1/71	24C. NAME OF CEMETERY OR CREMATORY Moreland Mem Pk	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR Leonard Buck Inc. Baltimore, Md		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

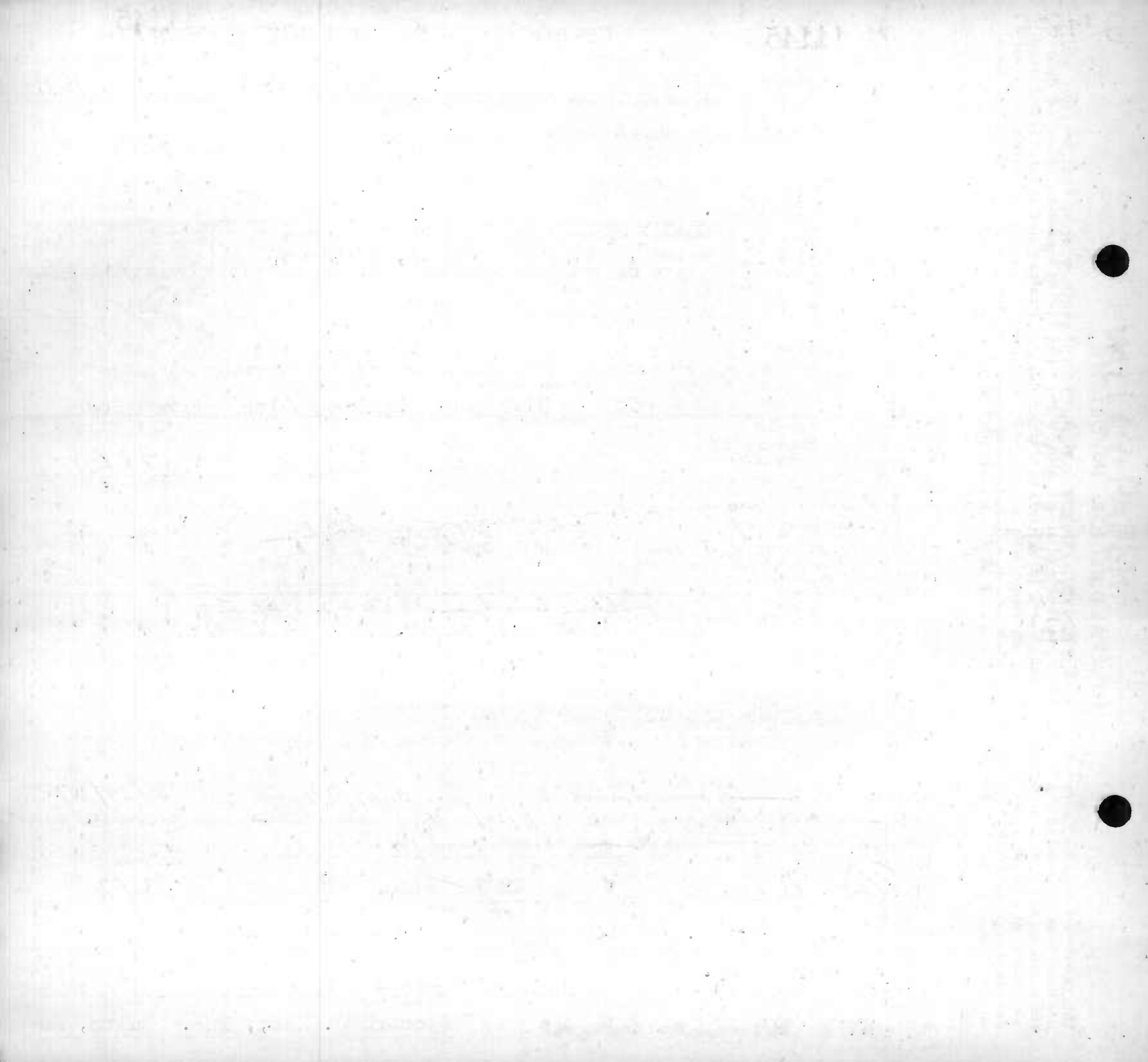
BALTIMORE CITY HEALTH DEPARTMENT				71 11144		REG. NO. 71 11144	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		MAY C. LaVOIE		Nov. 28, 1971		10:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
90 GOULD'S CONVALESARIUM				Maryland		AA	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				1399 Rain Bow Dr			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	11. Under 1 Yr. Months Days		
female	caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 23, 1894	77			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Georgia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James O'Connell				Martha Hanrahan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		220-14-6412		Andrew R LaVoie Sr		6116 Everall Ave	
18. 519.0 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				10 days			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Recurrent Pneumonia			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Atherosclerosis			
				Cachexia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Hypertension; Arteriosclerotic Heart Disease; Gout; Peptic Ulcer; Hiatal Hernia; Chronic Brain Syndrome			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 9/24/1971 to 11/28/1971, that (I) (we) last saw the deceased alive on 11/22/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Albert B. Bradley				11/29/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Albert B. Bradley				4900 Belair Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/1/71		Parkwood		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 2 1971		Robert E. Farber, R.D.		Leonard J. Ruck, Inc.-Balto, Md.-14			



FUNERAL DIRECTOR: IMPORTANT

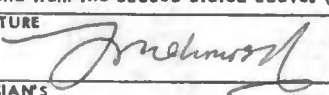
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

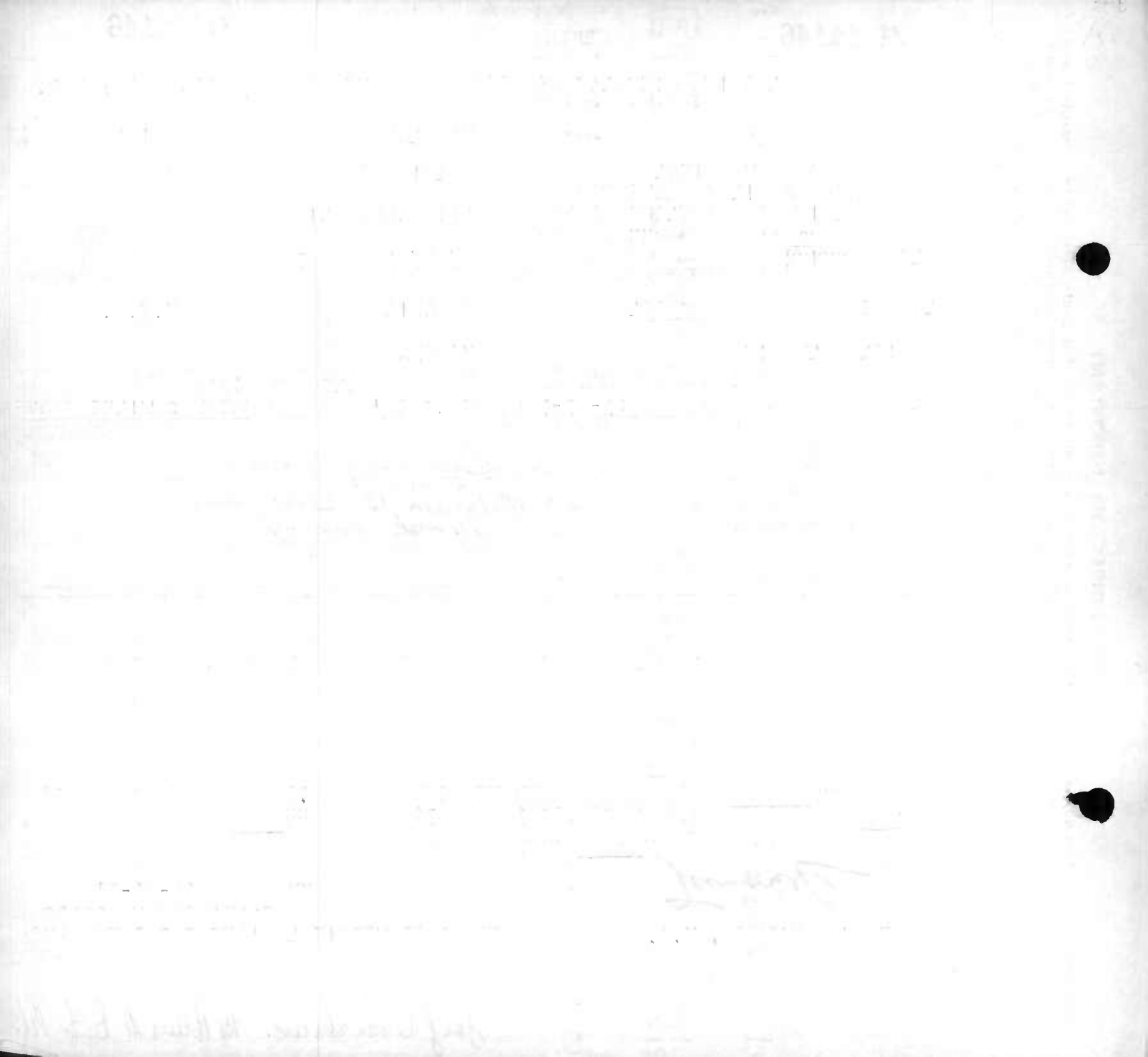
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11145	
BIRTH NO. 71 11145		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) George Soules			2. DATE AND HOUR OF DEATH Nov 29 1971 8:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalesarium Belair Rd.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY 2631 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4209 Mary Ave		
5. SEX Male	6. RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 23, 1897	9. AGE (In years last birthday) 74	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greece	
13. FATHER'S NAME James Soules			14. MOTHER'S MAIDEN NAME Sophia Koznetis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 567 18 9197		17. INFORMANT Mrs Lillian Soules	
				ADDRESS Same Above	
18. 492 X 4 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Bronchitis, Chronic Obstructive Pulmonary Disease, Heart Failure, Aortic Aneurysm, Diabetes Mellitus, Hypertension, Chronic Kidney Disease, Chronic Liver Disease, Chronic Pancreatitis, Chronic Spleen Enlargement, Chronic Stomach Enlargement, Chronic Throat Infection			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pneumonia (B) Chronic Obstructive Emphysema DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Bronchitis, Chronic Obstructive Pulmonary Disease, Heart Failure, Aortic Aneurysm, Diabetes Mellitus, Hypertension, Chronic Kidney Disease, Chronic Liver Disease, Chronic Pancreatitis, Chronic Spleen Enlargement, Chronic Stomach Enlargement, Chronic Throat Infection		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs year
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/11/1971 to 11/29/1971 , that (I) (was) last saw the deceased alive on 11/29/1971 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B Bradley				23B. DATE SIGNED 11/30/71	
23C. PHYSICIAN'S NAME (Type) Dr Albert B. Bradley				23D. ADDRESS 4900 Belair Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 3 71		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.	
				ADDRESS Balto, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11146	
BIRTH NO. 71 11146							
1. NAME OF DECEASED (Type or Print) MOLNARIU, NICHOLAS DE METRO				2. DATE AND HOUR OF DEATH NOVEMBER 30, 1971 10:33 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21230 2533			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE 6. RACE CAUCASIAN 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 08/02/93		9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10B. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) ROMANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DANIEL MOLNARIU				14. MOTHER'S MAIDEN NAME VERONA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-07-7838		17. INFORMANT BALTO MD 21229	
				ADDRESS ST AGNES' RECORDS CATON & WILKENS AVE			
18. 151.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Carcinoma of Stomach DUE TO, OR AS A CONSEQUENCE OF: with Metastasis to Liver, Lungs and Pleural coverings. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that XIX (this hospital) attended the deceased from NOVEMBER 2 19 71 to NOVEMBER 30 19 71 that XX (we) last saw the deceased alive on NOVEMBER 30 19 71 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED 12-01-71			
23C. PHYSICIAN'S NAME (Type) TARIQ MAHMOOD, M.D.				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/71		24C. NAME OF CEMETERY or CREMATORY Green Haven Cem.		24D. LOCATION (City, town, or county) (State) Green Broomer Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR John J. Caplan, Director		ADDRESS 901 Hollins St. Balt. Md.	



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71 11147

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11147

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEROY ANDERSON, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD 11 28 1971 8:16 p.m.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1604	
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Dec. 12, 1951		10. AGE (In years last birthday) 19		E. STREET AND NUMBER 1802 W. Mosher St.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Leroy Braxton	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Christine Anderson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-56-5973		18. INFORMANT ADDRESS Mrs. Christine Wilson 1802 Mosher Street	
19. E 985X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 7		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house		22C. WHERE DID IT IN BALTIMORE CITY, GIVE EXACT LOCATION) 1301 N. Fulton Ave.	
22D. TIME OF INJURY (APPROX.) 11-28-71 7:50 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Undetermined	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-29-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-2-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971			
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe Street			

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BALTIMORE CITY HEALTH DEPARTMENT

71 11148

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11148

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Joe

JOSEPH L. EPPS

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 St. Agnes Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

2047

6. SEX

male

7. RACE

negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (in years
last birthday) 29If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

36 N. Monastery Ave.

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Zingle Epps

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Anna Benlow

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.
219-40-3898

18. INFORMANT

ADDRESS

Mrs. Sarah Epps 36 N. Monastery Avenue

19.

E 965X 1

CAUSE OF DEATH

Gunshot wound of neck

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
house22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?
74 N. Monastery Ave. 204722D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
11-27-71 a

(Year) (Hour)

22E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot while at a party.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-27-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-1-71

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 2

1971

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

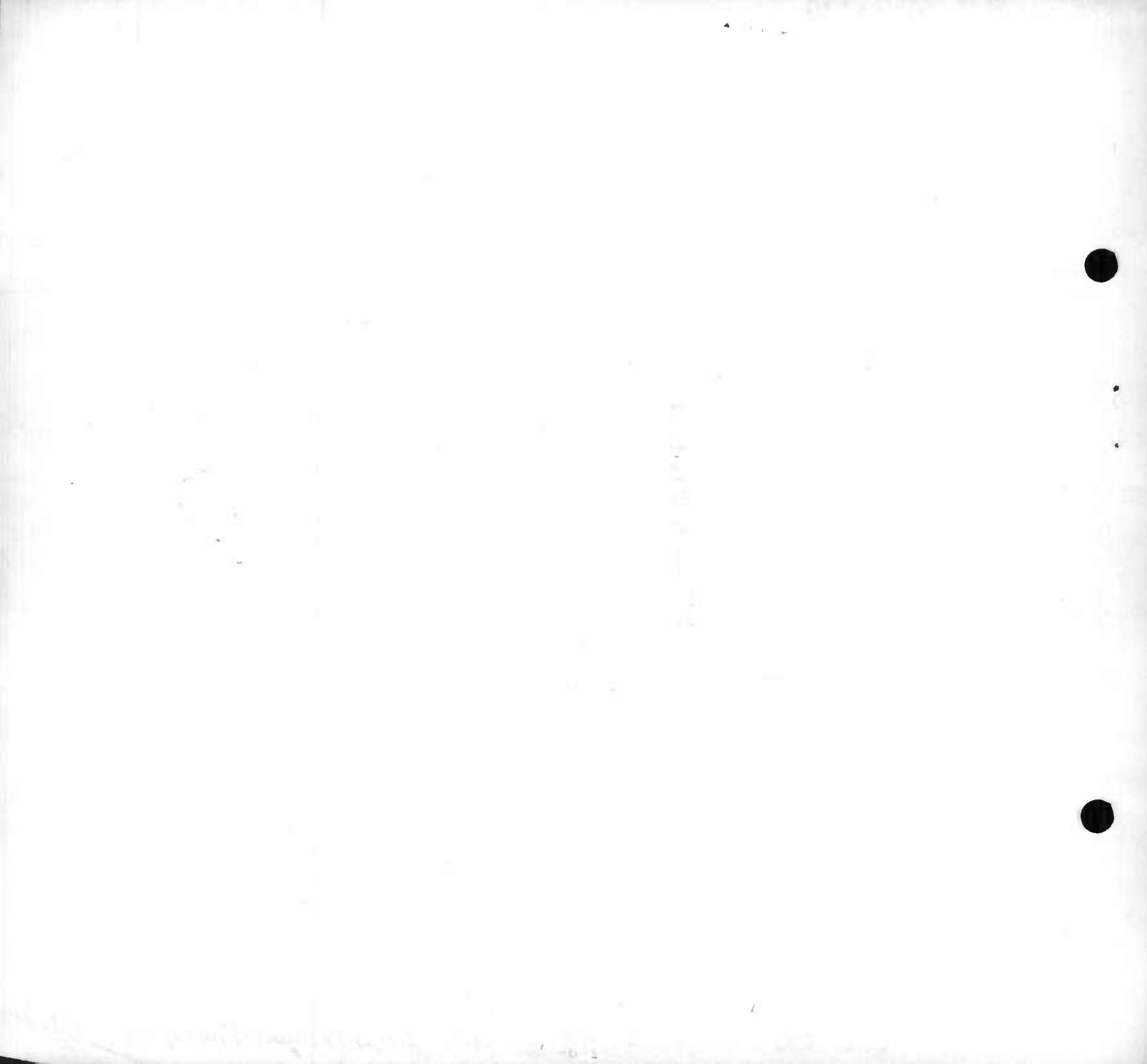
Arlington S. Phillips 1727 N. Monroe Street

N 874.1



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 11149		BALTIMORE CITY HEALTH DEPARTMENT		71 11149	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>RAGSDALE, SAM.</u>			2. DATE AND HOUR OF DEATH <u>11/26/71</u> <u>3-05 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL OF MARYLAND.</u> <u>46</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1608</u>		
5. SEX <u>MALE</u> 6. RACE <u>NEGRO</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9-22-17</u> 9. AGE (In years last birthday) <u>54</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>William Ragsdale</u>			14. MOTHER'S MAIDEN NAME <u>Elsie Hughes</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>228-12-9304</u>		
17. INFORMANT <u>Rachel Ragdale</u>			ADDRESS <u>-3807 Flowerton Rd</u>		
18. <u>E 880X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, leading rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): <u>CERTIFICATION APPROVED BY</u> <u>CHIEF OF MEDICAL EXAMINER</u> <u>St. Louis</u> CAUSE OF DEATH <u>SUBLUXATION OF CERVICAL SPINE</u> (A) IMMEDIATE CAUSE <u>NEGATIVE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>WITH CEREBRAL EDEMA + QUADRIPLEGIA</u> <u>Quadruplegia Following Spinal</u> DUE TO, OR AS A CONSEQUENCE OF: <u>INJURY</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3d.</u>					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>11-23-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cervical SUBLUXATION</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>BALTO, 3807 FLOWERTON RD</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>11-20-71</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>FELL DOWN BASEMENT STEPS</u>	
22. I certify that <u>He</u> (this hospital) attended the deceased from <u>11-20-71</u> to <u>11-26-71</u> that <u>He</u> (we) last saw the deceased alive on <u>11-26-71</u> and that <u>He</u> (we) (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sein Lwin</u>			23B. DATE SIGNED <u>11-26-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>SEIN LWIN</u>			23D. ADDRESS <u>LUTHERAN HOSPITAL OF MARYLAND.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-30-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Arlington Memorial Park</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, MD</u>		24E. LOCATION (State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u>	
25D. ADDRESS <u>1727 N. Mount St</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F 5201		71 11150		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11150	
BIRTH NO. 71 11150				1. NAME OF DECEASED (Type or Print) WEHNER J. FUNKE			
2. DATE AND HOUR OF DEATH 11/29/71 at 1:40 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 702				5. CITY OR TOWN Baltimore			
6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				7. STREET AND NUMBER 2516 Jefferson St.			
FULL NAME OF HOSPITAL OR INSTITUTION Church Home + Hospital 35 100 N. Broadway, Baltimore		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		8. DATE OF BIRTH 09/02/02		9. AGE (In years lost birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Copper smith		10B. KIND OF BUSINESS OR INDUSTRY Copper smith		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Funke				14. MOTHER'S MAIDEN NAME Mollie Trumellon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-09-2985		17. INFORMANT Chk Mrs. Catherine H. Funk - 2516 Jefferson St.			
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma colon & metastasis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma colon & metastasis			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 311/19/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma colon		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 11/14/71 to 11/29/71 and that (I) (we) lost saw the deceased alive on 11/29/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
23A. SIGNATURE S. P. GARDHAR M.D.				23B. DATE SIGNED 11/29/71		23C. PHYSICIAN'S NAME (Type) S. P. GARDHAR M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/2/71		24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEM.		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR —		25D. ADDRESS —	



22301

71 11151

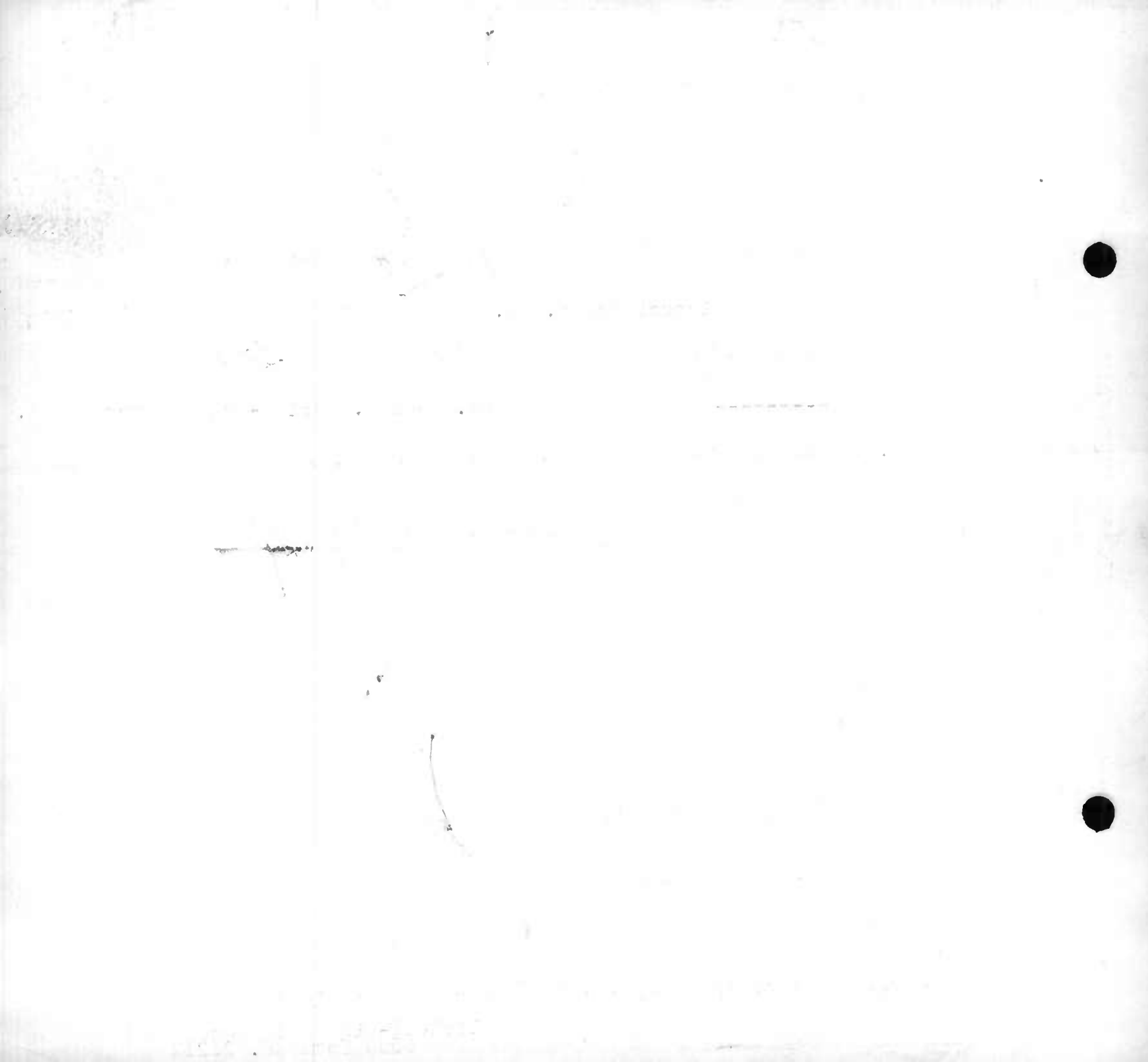
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11151

BIRTH NO. 71 11151		2. DATE AND HOUR OF DEATH 26 November 1971 1:05 P. M.	
1. NAME OF DECEASED (Type or Print) John Lucido		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hosp. 44		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX male 6. RACE white		E. STREET AND NUMBER 721 Cedarcroft Rd (721)	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/22/14 9. AGE (in years last birthday) 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Piracci Const. Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Sal Lucido		14. MOTHER'S MAIDEN NAME Theresa Laberto	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Agnes R. Lucido		ADDRESS 721 Cedarcroft Rd.	
18. 154.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinomatosis (B) Cause of the Rectum DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 6/4/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Small Bowel Obstruction	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/2 1971 to 6/16 1971 that (I) (we) last saw the deceased alive on 7/7/71 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George Salasogal		23B. DATE SIGNED 26 November 71	
23C. PHYSICIAN'S NAME (Type) George Salasogal		23D. ADDRESS Union Memorial Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 11/29/71	
24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. 21212	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

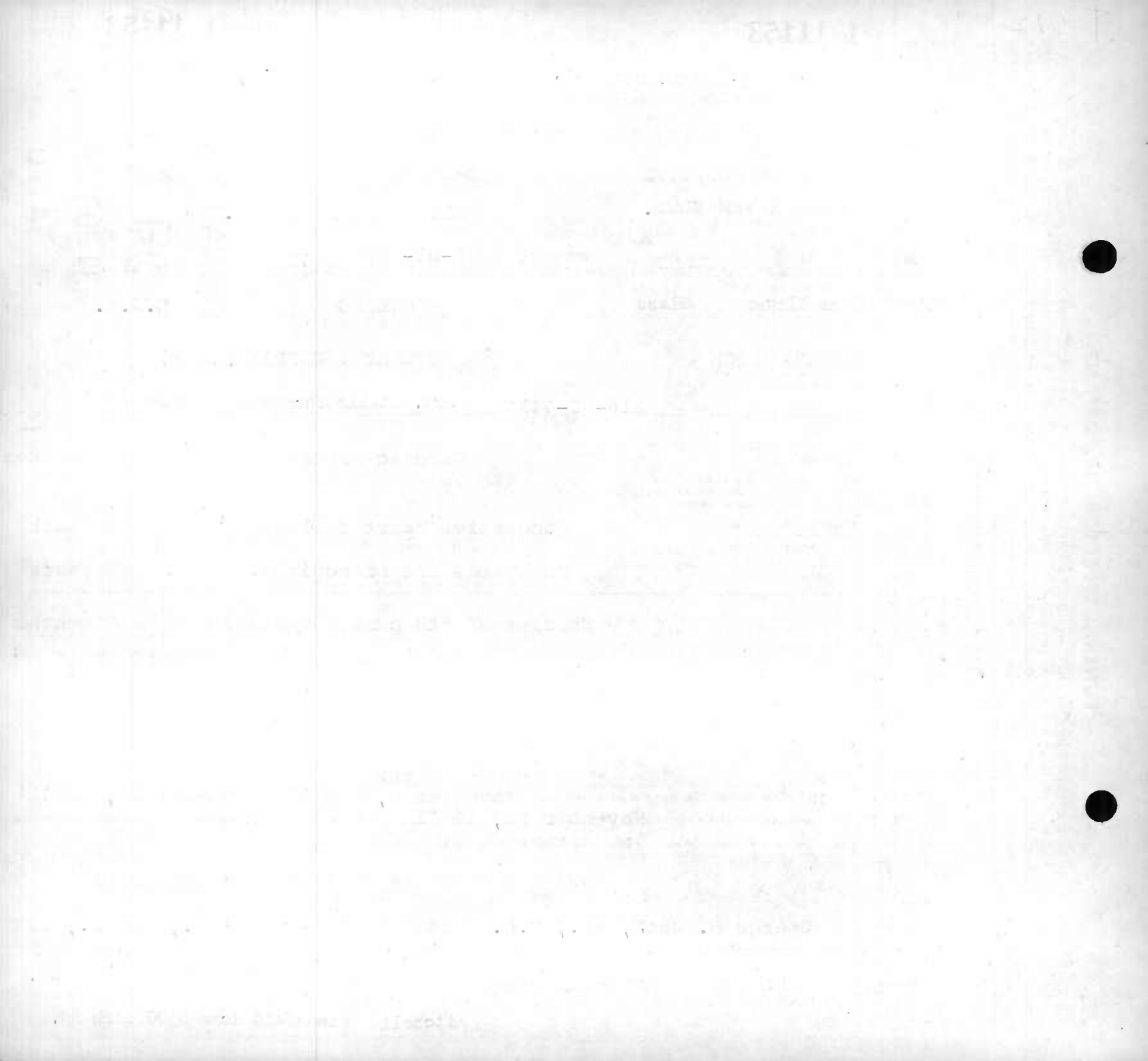


12/7/71 - Correction form from funeral director.

Life.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11153	
BIRTH NO. 71 11153		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) George Thompson Sr.		2. DATE AND HOUR OF DEATH November 28, 1971 7:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOOD SAMITAN HOSPITAL 5601 LOCH RAVEN BLVD.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2768 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6130 PARKWAY DR.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-07- 99	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Glass Blower		10B. KIND OF BUSINESS OR INDUSTRY Glass		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL THOMPSON			
14. MOTHER'S MAIDEN NAME ESTELLE (CARRIE BROWN)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 216-05-7417		17. INFORMANT ADDRESS Mrs. Estelle Thompson same			
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 years (B) DUE TO, OR AS A CONSEQUENCE OF: 3 years (C) DUE TO, OR AS A CONSEQUENCE OF: 2 months		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED XXX		20A. AUTOPSY? (Yes or No) XXX	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) XXX		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) XXX	
21D. TIME OF INJURY (APPROX.) XXX		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? XXX	
22. I certify that (H) (this hospital) attended the deceased from November 8, 19 71 to November 28, 19 71 , that (I) (we) last saw the deceased alive on November 28, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE <i>George H. Sack, Jr.</i> M.D.				23B. DATE SIGNED 11/28/71	
23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D.				23D. ADDRESS 5600 Loch Raven Blvd., Balto., 2121	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/1/71		24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery	
24D. LOCATION (City, town, or county) Dogwood Rd Woodlawn Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR 19710000		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11154

BIRTH NO. 71 11154

1. NAME OF DECEASED
(Type or Print)

Charles Miller

2. DATE AND HOUR OF DEATH

November 30, 1971

7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 6212 Brook Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

6212 Brook Avenue

5. SEX

Male

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

June 15, 1898

9. AGE (in years last birthday)

73

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plumber & Heating

10B. KIND OF BUSINESS OR INDUSTRY

Supply Co. Central Metal &

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Miller

14. MOTHER'S MAIDEN NAME

Sarah E. Gregory

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

211-01-7648A

17. INFORMANT

Mrs. Ida M. Miller 6212 Brook Avenue Balto.

ADDRESS

21206

18. 410.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (1) this hospital attended the deceased from MSY 19 to Nov 28 1971 that (2) we last saw the deceased alive on Nov 28 1971 and that (3) my own opinion death occurred on the date and hour and from the causes stated above. (4) we did not view the body after death.

23A. SIGNATURE

Ramon Roig, M.D.

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Nov 30, 1971

23C. PHYSICIAN'S NAME (Type)

Ramon Roig, M.D.

DEGREE

7401 Osler Drive Baltimore, Md. 21204

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-3-71

24C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

Parkville

(City, town, or county)

Balto.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1971

25B. NAME OF REGISTRAR

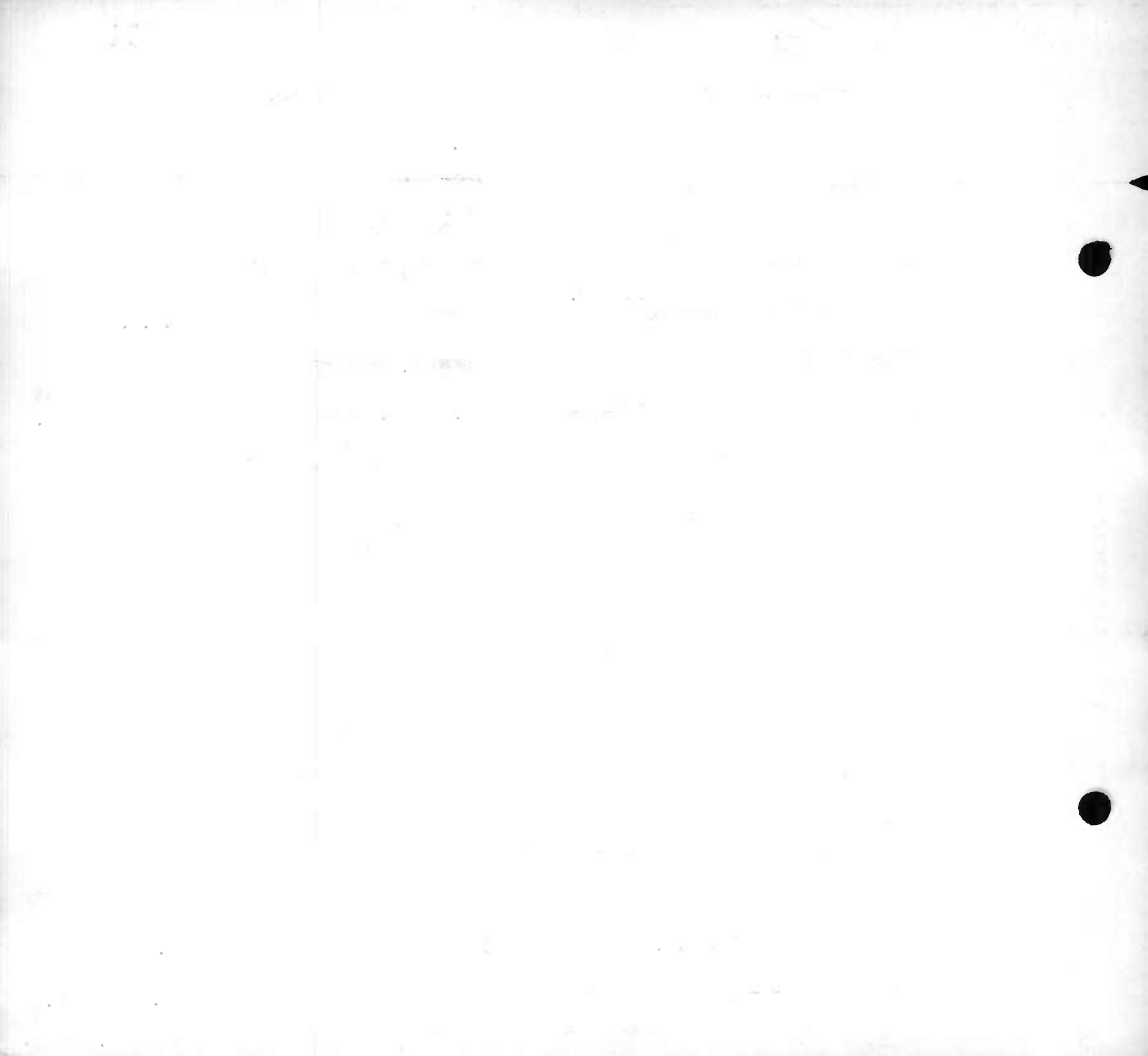
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Belair Rd. Balto.

ADDRESS

21236



71 11155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11155

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Nicholas Philip Pellegrini Nickolis Pellegrini		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 11 Day 30 Year 71 Hour 10:20 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 4206 Berger Avenue		3. DATE PRONOUNCED DEAD Month 11 Day 30 Year 71 Hour 10:20 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec. 6, 1925		10. AGE (In years last birthday) 45	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pasquale Pellegrini		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant	
15. MOTHER'S MAIDEN NAME Giovanna Ninetta DiBona		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 219-22-4831		18. INFORMANT ADDRESS Anna Pellegrini 4206 Berger Avenue 21206	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF: disease (B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 12-1-71			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE Dec. 4, 1971	
24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Cem		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Dippel Bro's Inc. 7110 Belair Rd. 21206		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11156</u>	
BIRTH NO. <u>71 11156</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Daisy T. Sivits</u>			2. DATE AND HOUR OF DEATH <u>December 1, 1971</u> <u>5:30 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2745</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3901 Northern Parkway</u>			C. CITY OR TOWN <u>Overlea</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>			6. RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>June 21, 1893</u>			9. AGE (In years lost birthday) <u>78</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>teacher</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Union Town, Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Joseph Trombly</u>		
14. MOTHER'S MAIDEN NAME <u>Sara Jane Liston</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>164-38-3658</u>			17. INFORMANT <u>Melda Cochran</u>		
ADDRESS <u>4221 Harcourt Road 21206</u>			18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic carcinoma</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>diffuse Carcinoma of rectum</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0***</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (1) (this hospital) attended the deceased from <u>10/17</u> <u>1970</u> to <u>12/1</u> <u>1971</u> , that (1) (we) last saw the deceased alive on <u>12/1</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert E. Martin M.D.</u>				23B. DATE SIGNED <u>Dec. 1, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert Martin M.D.</u>				23D. ADDRESS <u>3201 North Charles Street Balto., Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>Dec. 4, 71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hill Grove Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Connellsville, Pennsylvania</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1971</u>			
25B. NAME OF REGISTRAR <u>Joseph E. Gaber, R.D.</u>		25C. FUNERAL DIRECTOR <u>The Dippel Brothers, Inc</u>			
ADDRESS <u>7110 Belair Rd.</u>					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 11157		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11157	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) VIRGINIA REID		2. DATE AND HOUR OF DEATH 11/28/71 11:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 48 MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2515 MADISON AVE 1301			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/10/27	9. AGE (in years last birthday) 44
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME JOHN L HILL		14. MOTHER'S MAIDEN NAME ENIDE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 226-32-1405		17. INFORMANT (sister) Laura Holmes ADDRESS (SAME)	
18. 517A I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema and Infection		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic obstructive pulmonary disease		20. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Granuloma, bilateral	
21. (B) DUE TO, OR AS A CONSEQUENCE OF: Malnutrition		22. (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-9-71 19 to 11-28-71 19 that (I) (we) last saw the deceased alive on 11/28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Y. Faulkner MD				23B. DATE SIGNED 11/28/71	
23C. PHYSICIAN'S NAME (Type) Michael Y. Faulkner MD				23D. ADDRESS MD. GEN Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/4/71		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971			
25B. NAME OF REGISTRAR Robert E. Gaber, R.D.		25C. FUNERAL DIRECTOR Ado Iphus Halstead ADDRESS 1206 W North Ave			



71 11158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11158

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FREDERICK BOUNDS

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

Carroll

6. SEX

male

7. RACE

white

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Sykesville

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

July 2, 1888

10. AGE (In years
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

Rt. 3

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

USA

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Teller

14B. KIND OF BUSINESS OR INDUSTRY

Banking

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Bertha Bounds Sykesville, Md.

19. 441.2

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Retroperitoneal hemorrhage

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

rupture of abdominal aortic aneurysm

DUE TO, OR AS A CONSEQUENCE OF:

(C)

arteriosclerotic cardiovascular disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-29-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-2-71

24C. NAME OF CEMETERY or CREMATORY

Lake View Cemetery

24D. LOCATION

(City, town, or county)

(State)

Sykesville

Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 2

1971

25B. NAME OF REGISTRAR

Robert E. Jaber, M.D.

25C. FUNERAL DIRECTOR

Harry W. Haight

ADDRESS

Sykesville, Md.

11158

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CERTIFICATE OF DEATH

REG. NO. 71 11159

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Cofield, Maude Ida

2. DATE AND HOUR OF DEATH

11/30/71 9¹² A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Corro II

5600

C. CITY OR TOWN

Sykesville, Md

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

Oakland Mills

5. SEX

Female

6. RACE

Caucasian

7. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4-23-92

9. AGE (in years
last birthday)

79

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Isaac James Pulliam

14. MOTHER'S MAIDEN NAME

Lucinda Dixon

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

4940 Eastern Avenue

BCH: RECORDS Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

A. IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Renal Failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

36 hrs

B. MEDICAL HISTORY

C. MEDICAL HISTORY

DUE TO, OR AS A CONSEQUENCE OF:

2070 3° Burns

5 days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED

IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR

(If in Baltimore City, give exact location)

Oakland Mills

Corro II

5600

21D. TIME OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

11 24 71 7AM

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☒

21F. HOW DID INJURY OCCUR

Self inflicted

22. I certify that (I) (this hospital) attended the deceased from 11/24/71 19 to 11/30 1971
that (I) (we) last saw the deceased alive on 11/29/71 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

L. Turnbaugh

M.D.

Attending ☐

Phys.

Med. ☐

Director

Staff ☒

Phys.

23B. DATE SIGNED

11/30/71

23C. PHYSICIAN'S
NAME (Type)

L. Turnbaugh, M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-3-71

24C. NAME of CEMETERY or CREMATORY

Deer Park Cemetery

24D. LOCATION

(City, town, or county)

Reisterstown

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1971

25B. NAME OF REGISTRAR

Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR

Harry W. Haight

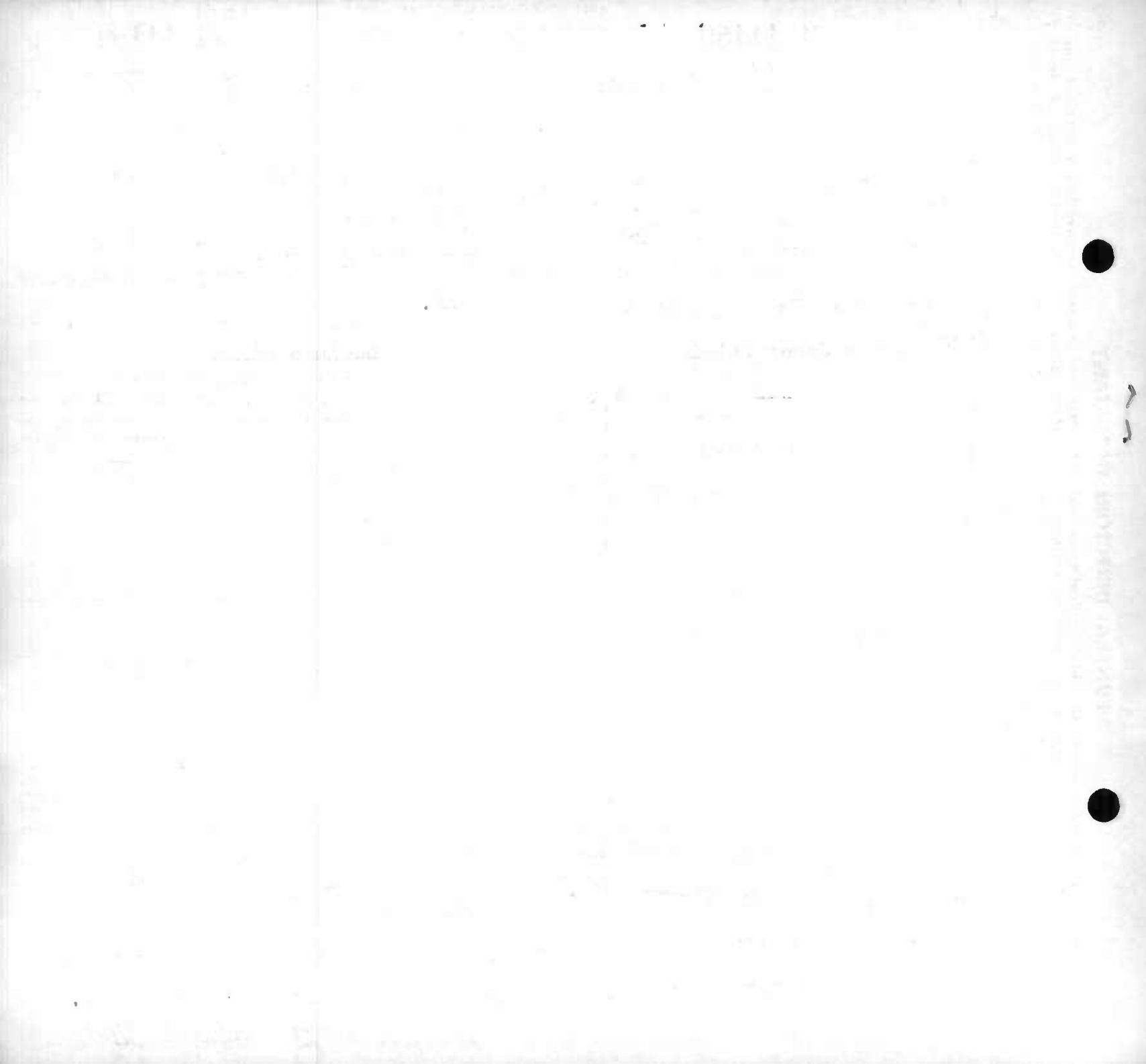
Sykesville, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MEDICAL CERTIFICATION



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11160	
BIRTH NO. 71 11160		1. NAME OF DECEASED Type or Print ERMA M. CURSEY		2. DATE AND HOUR OF DEATH November 28, 1971 11:02 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton Avenue Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2366 Washington Blvd.			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/12	9. AGE (in years last birthday) 59	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Detective		10B. KIND OF BUSINESS OR INDUSTRY Stewart Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul Falk		14. MOTHER'S MAIDEN NAME Ada M. Lester	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-20-5685		17. INFORMANT Mr. Earl G. Cursey, 2366 Washington Blvd.	
18. 492 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Myocardial Infarction 1. This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Long standing Emphysema		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 28, 1971 to November 28, 1971 that (I) (we) last saw the deceased alive on November 28, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nicholas Stratigakakis				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Nicholas Stratigakakis M.D.		23D. ADDRESS St. Agnes Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-1-1971		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

20

1. The first part of the report is devoted to a general survey of the situation in the country.

2. The second part of the report is devoted to a detailed analysis of the economic situation.

3. The third part of the report is devoted to a detailed analysis of the social situation.

4. The fourth part of the report is devoted to a detailed analysis of the political situation.

5. The fifth part of the report is devoted to a detailed analysis of the cultural situation.

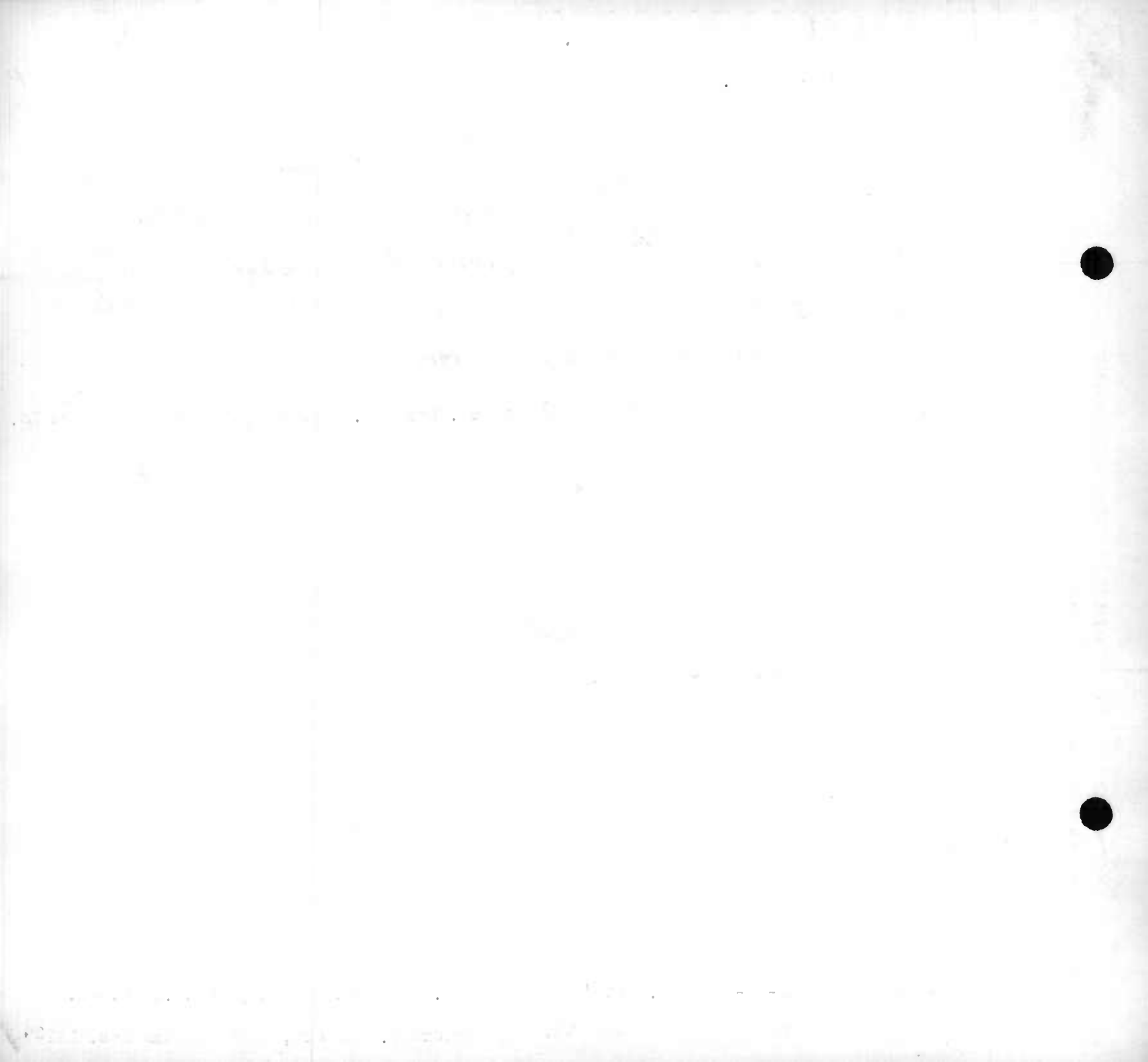
6. The sixth part of the report is devoted to a detailed analysis of the international situation.

7. The seventh part of the report is devoted to a detailed analysis of the future prospects of the country.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital; (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11161	
BIRTH NO. 71 11161		DATE AND HOUR OF DEATH 11/26/71 6:45 P.M.	
1. NAME OF DECEASED (Type or Print) FRANK X. HUPPMANN		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD BON SECOURS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL		C. CITY OR TOWN CATONSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/13/03 9. AGE (in years last birthday) 68 yr.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANCIS JOSEPH HUPPMANN		14. MOTHER'S MAIDEN NAME MARY CATHERINE ZOLL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 218-03-7042	
17. INFORMANT Mrs. Marie C. Huppman		ADDRESS 21228	
18. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 11/18/71 19A. DATE OF OPERATION 11/18/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AK amputation of leg due to gangrene 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) no 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 1st 1971 to November 26th 1971 that (I) (we) last saw the deceased alive on November 26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Aurora Bichaironarysophon M.D.		23B. DATE SIGNED 11/26/71	
23C. PHYSICIAN'S NAME (Type) ARVORANEE BICHAIRONARONG		23D. ADDRESS BON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-30-71	
24C. NAME OF CEMETERY or CREMATORY St. Mary's College Cem.		24D. LOCATION (City, town, or county) (State) Catonville, Balto., Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Tabor M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21239	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>604-20161</u>	
BIRTH NO. <u>71-203071</u>		11162	
1. NAME OF DECEASED (Type or Print) <u>Cherry boy Debra</u>		2. DATE AND HOUR OF DEATH <u>11/27/71</u> <u>10²⁰ P M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-27-71</u> 9. AGE (in years last birthday) <u>1</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ARTHUR HINDS</u>		14. MOTHER'S MAIDEN NAME <u>DEBRA CHERRY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>BCH: RECORDS Baltimore, Maryland 21224</u>		ADDRESS <u>4940 Eastern Avenue</u>	
18. <u>743.01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY WITH ENCEPHALOCOELE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>11/27/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> 19 <u>71</u> to <u>11/27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/27</u> 19 <u>71</u> and that (in my) (four) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.			
23A. SIGNATURE <u>Alan R. Fleischman M.D.</u>		23B. DATE SIGNED <u>11/27/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALAN R. FLEISCHMAN M.D.</u>		23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>11-29-71</u>	
24C. NAME of CEMETERY or CREMATORY <u>Baltimore City Hospitals</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland 21224</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		ADDRESS	

SP

S 455

71 11163

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11163

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Dennis A. Solomon

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
11Day
29Year
71Hour
6:10 P. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
OR INSTITUTION

890 Linden Avenue

3. DATE
PRONOUNCED DEADMonth
11Day
29Year
71Hour
6:10 P. M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 1701

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

11-5-13

10. AGE (In years last birthday)

58

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

890 Linden Avenue

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Leon Solomon

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Elizabeth

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

237-03-8491

18. INFORMANT

ADDRESS

Virginia Solomon, 890 Linden Avenue

19. CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Hypertensive cardiovascular
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☒ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-1-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-3-71

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore

Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 2

1971

Robert E. Fisher, M.D.

Wm. C. March 928 E. North Avenue

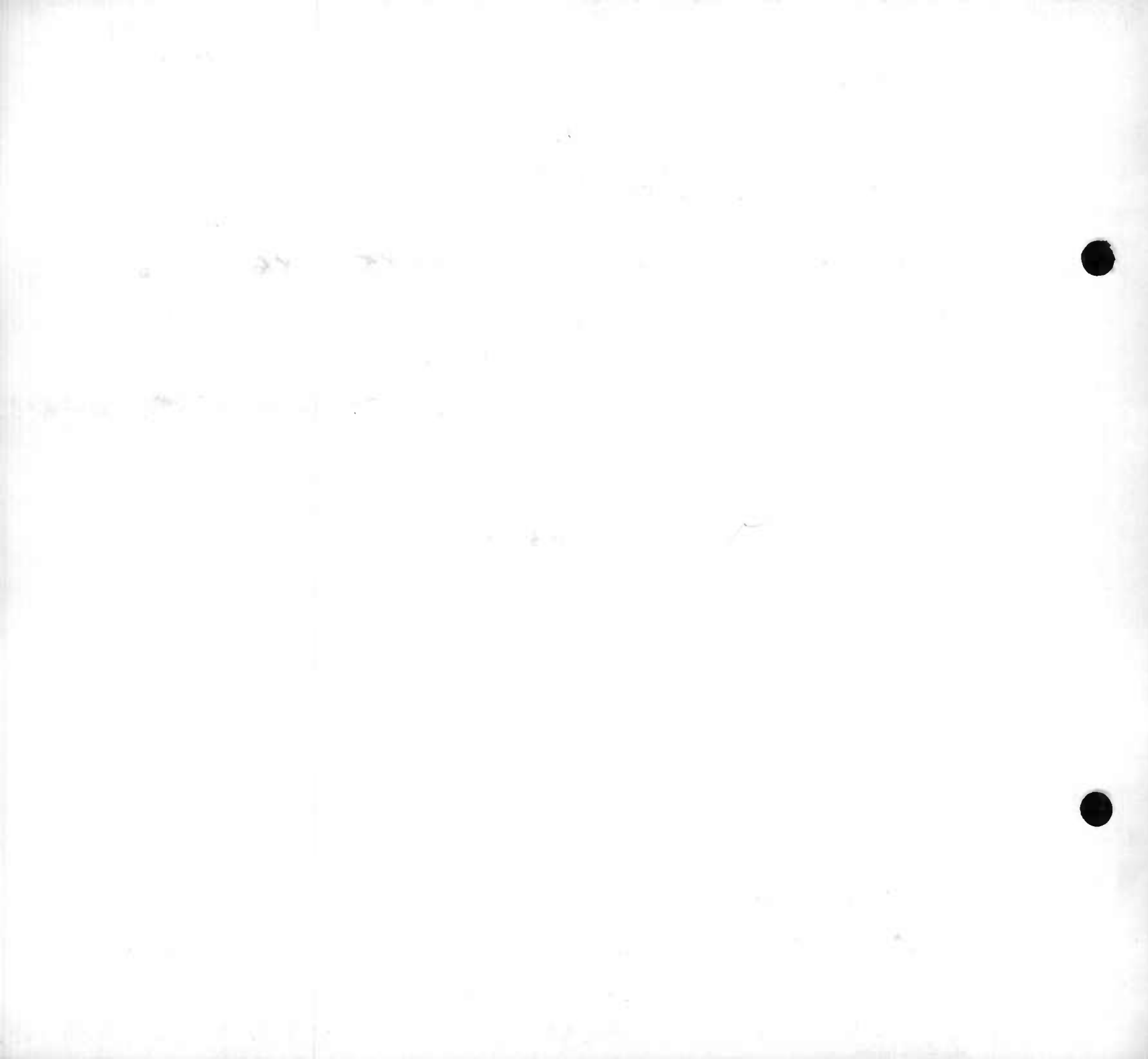
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11164	
BIRTH NO. 71 11164		1. NAME OF DECEASED (Type or Print) WRIGHT, WILLIAM Z.	
2. DATE AND HOUR OF DEATH 11-29-71 08:05 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1510		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3501 CARSDALE AVE. #07		5. SEX Male 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 3-31-1914 9. AGE (In years last birthday) 57 If Under 1 Yr. Months Days If Under 24 Hrs. Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10B. KIND OF BUSINESS OR INDUSTRY Ford, Detroit Mich. Virginia		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Willie C. Wright	
14. MOTHER'S MAIDEN NAME Nellie Burrell		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-01-6801		17. INFORMANT ADDRESS Etta Frazier 3501 Carsdale Avenue	
18. 2341 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: (B) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: (C) ? DISCOLD LUPUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-17 19 71 to 11-29 19 71 that (I) (we) last saw the deceased alive on 11-29 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Peter Oroszuan		23B. DATE SIGNED 11-29-71	
23C. PHYSICIAN'S NAME (Type) PETER OROSZUAN MD		23D. ADDRESS 3 HAMMILL RD APT 5	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-2-71	
24C. NAME OF CEMETERY or CREMATORY Anticott Church Cemetery		24D. LOCATION (City, town, or county) (State) Glaster Co. Virginia	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Sabin, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVE.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11165	
71 11165		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>RATLIFF, James</u>		2. DATE AND HOUR OF DEATH <u>11-29-71</u> <u>6:00 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1605</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Dukeland Nursing Home</u> 1501 N. Dukeland St. Baltimore #21216		C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>Negro</u>		E. STREET AND NUMBER <u>2503 W. Lanvale St.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-20-85</u> 9. AGE (in years last birthday) <u>86</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Leggins</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Ratliff</u>		14. MOTHER'S MAIDEN NAME <u>Winney ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-6769</u>	
17. INFORMANT <u>Mrs. Dorothy Harris</u>		ADDRESS <u>2503 W. Lanvale St.</u>	
18. <u>412.41</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>CEREBRAL ARTERIOSECTOMY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBRAL ISCHEMIA</u>	
		(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:	
		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-21</u> <u>1969</u> to <u>11-29</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>11-29</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>James W. Harris, Jr.</u>		23B. DATE SIGNED <u>11-29-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>T. W. Harris M.D.</u>		23D. ADDRESS <u>4200 E. Edmondwood Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-3-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) <u>Anne Arundel Co. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME</u>		ADDRESS <u>3035 W. NORTH AVE.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11166</u>
BIRTH NO. <u>71 11166</u>				
1. NAME OF DECEASED (Type or Print) <u>DOROTHY PLOWDEN</u>		2. DATE AND HOUR OF DEATH <u>11/28/71</u> <u>11:15</u> p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1603</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>49 NORTH CHARLES GEN HOSP</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1711 W. LAFAYETTE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/27/13</u>	9. AGE (In years last birthday) <u>58</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>YWCA</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CLARENCE CONWAY</u>		
14. MOTHER'S MAIDEN NAME <u>HELEN CURTIS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>212-14-4678</u>		17. INFORMANT <u>Mrs. Helen Conway 1711 W. Lafayette</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RENAL FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.) <u>CHRONIC PYELONEPHRITIS</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 1/2 YEARS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2/</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> 19 <u>71</u> to <u>11/28</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>11/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>B. E. Faley, M.D.</u>		23B. DATE SIGNED <u>11/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>VENERACION</u>
23D. ADDRESS <u>NORTH CHARLES</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>12-2-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbues Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1971</u>		25B. NAME OF REGISTRAR <u>B. E. Faley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Hutter Funeral Home 3035 W. North Ave</u>

1950

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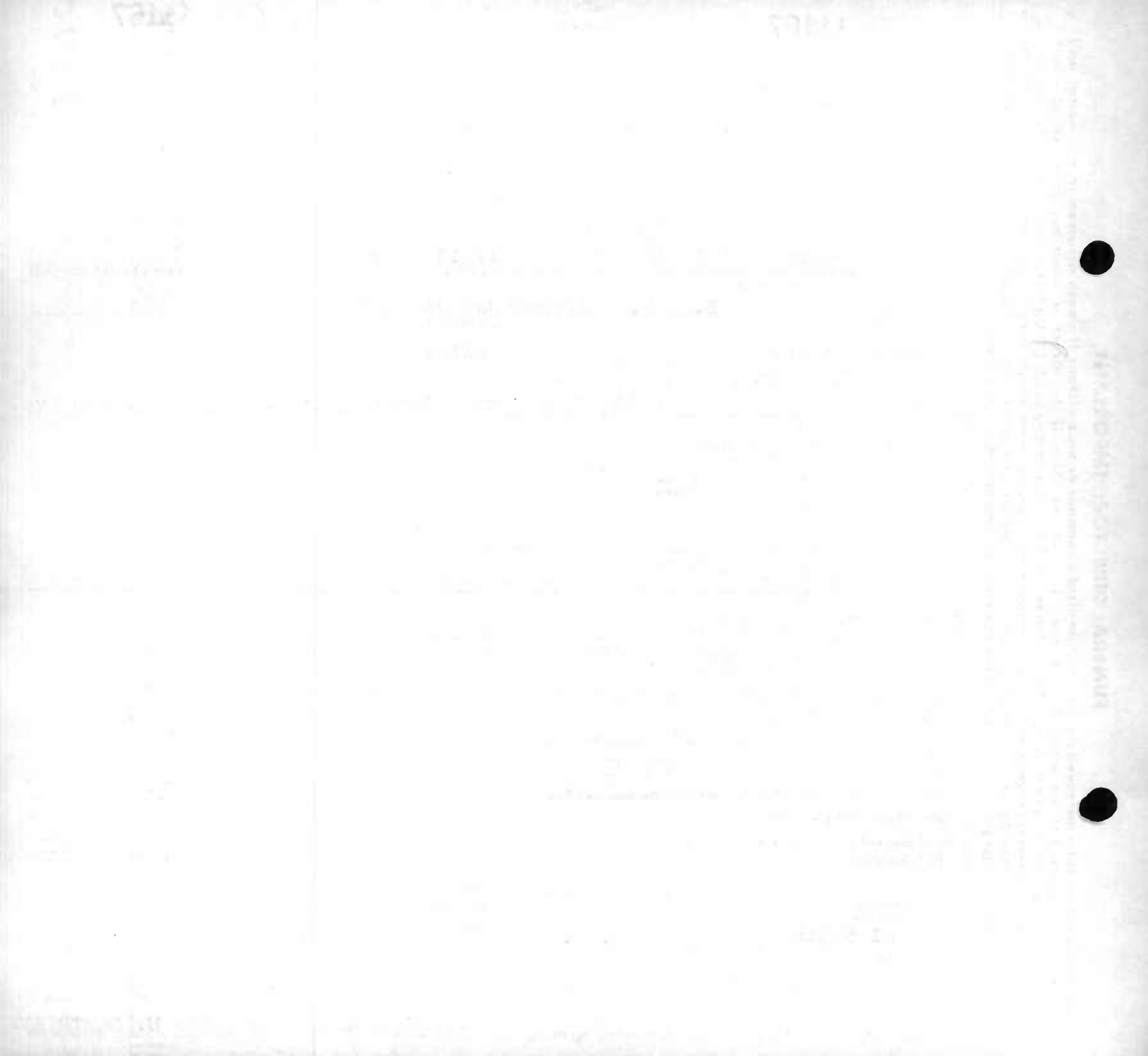
1950

1950

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11167	
BIRTH NO. 71 11167							
1. NAME OF DECEASED (Type or Print) Rufus L. Oakley				2. DATE AND HOUR OF DEATH November 29, 1971 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1505			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3022 Reisterstown Road				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3022 Reisterstown Road			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-1902	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chef		10B. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad		11. BIRTHPLACE (State or foreign country) Jamacia BWI		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Oakley				14. MOTHER'S MAIDEN NAME Hilda ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. A212-07-7894		17. INFORMANT Mrs. Alma G. Barnes ADDRESS 1805 N. Fulton Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 154111 Cancer of Rectum				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Cancer of Rectum		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/14/70	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. metastatic liver				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 10/14/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of Rectum		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/5 19 70 to 11/29 19 71 that (I) (we) last saw the deceased alive on 11/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sol Smith				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/1/71	
23C. PHYSICIAN'S NAME (Type) Sol Smith				23D. ADDRESS M. D. DEGREE 6810 Park Heights Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-3-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11168	
BIRTH NO. 71 11168		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HOLMES, GEORGE EDWARD			2. DATE AND HOUR OF DEATH 11/30/71 6:36 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 212/171702		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GEN. HOSPITAL			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE 6. RACE NEGRO			E. STREET AND NUMBER 530 DOLPHIN ST.		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH JULY 11-1923		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			9. AGE (In years last birthday) 48		
10B. KIND OF BUSINESS OR INDUSTRY MERLIN CONSTRUCTION			11. BIRTHPLACE (State or foreign country) VIRGINIA		
13. FATHER'S NAME George K. Holmes			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Rebecca Dawson			15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 223-24-6178			17. INFORMANT THOMAS HOLMES ADDRESS 2313 SARATOGA ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH RESPIRATORY ARREST			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL EDEMA		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) IRREVERSIBLE BRAIN DAMAGE DUE TO, OR AS A CONSEQUENCE OF: CORONARY INFARCTION		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II			(C) DUE TO CEREBRAL INFARCTION		
19A. DATE OF OPERATION 11-30-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED KIDNEY DONOR		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-27- 19 71 to 11-30- 19 71 that (I) (we) last saw the deceased alive on 11-30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE CHARO L. LADINA M.D.				23B. DATE SIGNED 11-30-71	
23C. PHYSICIAN'S NAME (Type) CHARO L. LADINA M.D.				23D. ADDRESS 1660 E. TREE CT. COCKEYSVILLE, MD. 21030	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-3-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Baltimore MD	
24D. LOCATION (City, town, or county) (State) Baltimore MD		25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR MORTON D. DYE		25D. ADDRESS 1701-1701		25E. NAME OF REGISTRAR Robert E. Taylor, R.D.	

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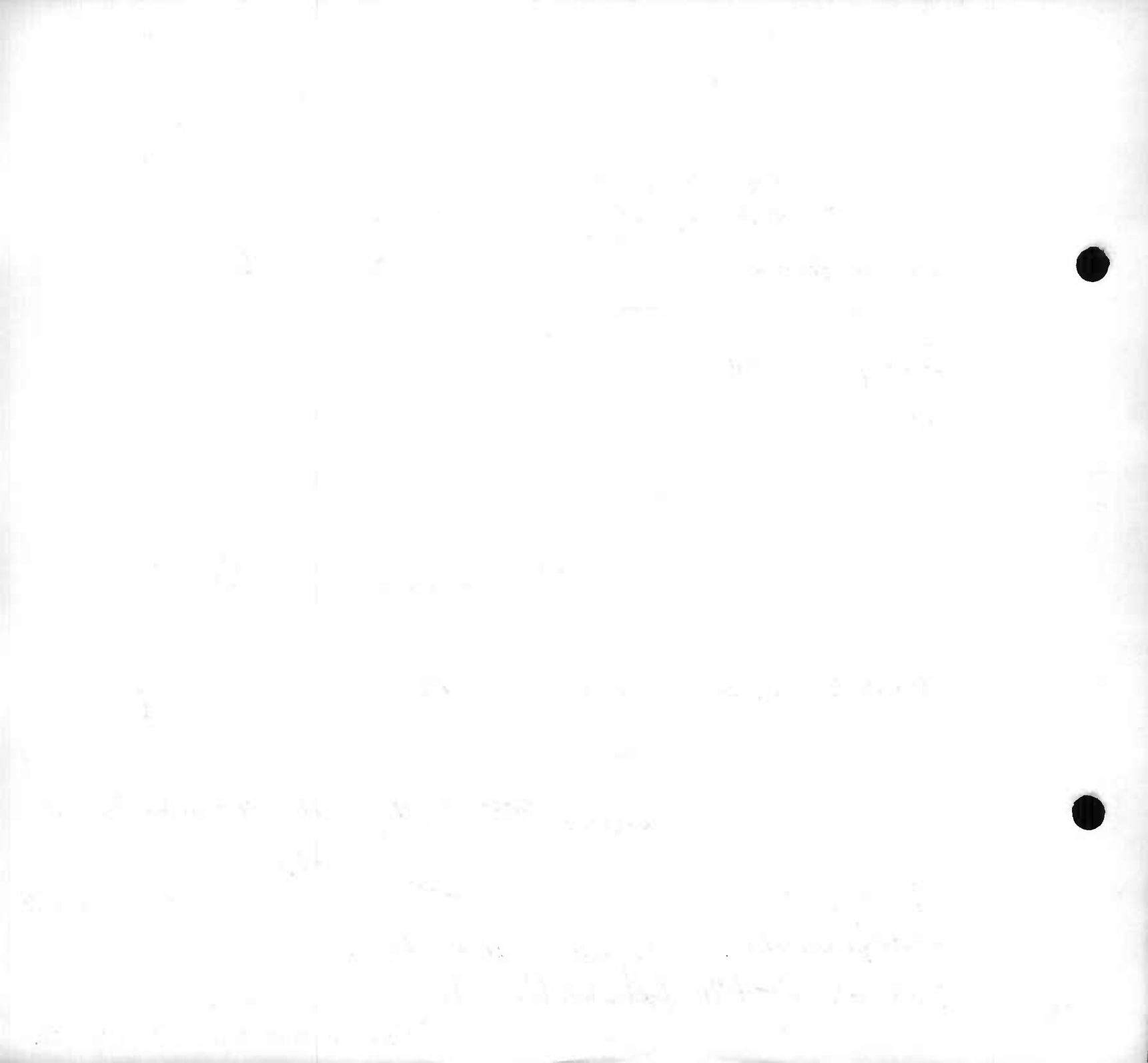
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11169
BIRTH NO. 71 11169				
1. NAME OF DECEASED (Type or Print) HELEN WEINBERG		2. DATE AND HOUR OF DEATH 11-30-71 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1301		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 818 BROOKS LANE BALTIMORE, MD.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX FEMALE		6. RACE BLACK		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 11-8-05
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		9. AGE (In years last birthday) 66 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
12. CITIZEN OF WHAT COUNTRY AMERICA		13. FATHER'S NAME DRUEY PASCHALL		
14. MOTHER'S MAIDEN NAME MAMIE CROXTON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 219-22-2128		17. INFORMANT Elmer Weinberg Address same address		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastasis to Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 weeks		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of Pancreas with liver metastasis, cholelithiasis, hepatitis (obstructive)		(B) DUE TO, OR AS A CONSEQUENCE OF: obstruction of common duct		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 10/25/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED pancreatic cancer with liver metastasis		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from October 11, 1971 to November 30, 1971 that (I) (we) last saw the deceased alive on Nov. 20, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Henry C. Welcome, M.D.		23B. DATE SIGNED Nov. 30, 1971		23C. PHYSICIAN'S NAME (Type) HENRY C. WELCONE, M.D., FAC.
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 12-4-71		24C. NAME OF CEMETERY OR CREMATORY Arbuthnot Memorial
24D. LOCATION (City, town, or county) (State) Baltimore, City, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		
25B. NAME OF REGISTRAR Robert E. Fairley, M.D.		25C. FUNERAL DIRECTOR MORION & DYETT FUNERAL HOME 1701 LAURENS		



S399 11170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11170

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WINNIE SCOTT		NOV 30, 1971 8:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE MARYLAND B. COUNTY BALTIMORE	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				1639 VINCENT CT. 21217	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-15-50	21	Unemployed
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Unemployed			Maryland		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Leroy Scott			Cora Savage		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			216-54-0476		
17. INFORMANT			4940 Eastern Avenue ADDRESS		
BCH: Records Baltimore, Maryland			21224		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CARDIOMYOPATHY one year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from SEPT 28 1971 to NOV 30 1971 that (2) (we) last saw the deceased alive on NOV 30 1971 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
ADEL Z. MAKARY M.D. DEGREE				NOV 30, 1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ADEL Z. MAKARY M.D. DEGREE				4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-4-71		Mt Calvary Corp. Baltimore, Md	
24D. LOCATION (City, town, or county)		24E. ST		24F. (State)	
BALTIMORE		BALTIMORE		MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 2 1971		Robert E. Fisher, M.D.		Mortimer Lyett F.H. 1701 Laurens	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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For a 1st Class Ticket to London
London & North Western Railway

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11171

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elliott L. West		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour November 30, 1971 4:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour November 30, 1971 4:30 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1606			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-5-55		10. AGE (In years last birthday) 16 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF U. S. A.	
13. FATHER'S NAME Lindsay M. West		14. MOTHER'S MAIDEN NAME Mary Granger	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) STUDENT		18. SOCIAL SECURITY NO. STUDENT	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E9651X GunsHOT wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) School	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Edmondson High School- 501 Athol Avenue		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 11-24-71 2:25 P. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/1/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens St.	

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71 11172

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11172

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)
Douglas McArthur Parham2. DATE
OF
DEATHKnown ☒
Estimated ☐Month
Day

Year

Hour

11
29

71

5:05 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

3. DATE
PRONOUNCED DEADMonth
Day

Year

Hour

11
29

71

5:05 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

11-4-44

10. AGE (in years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Sussex Cty, Virginia

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

E. STREET AND NUMBER

312 Grantley Avenue

13. FATHER'S NAME

Lee Parham

15. MOTHER'S MAIDEN NAME

Bessie Wright

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

John Parham 312 Grantley St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Massive pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-30-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-5-71

24C. NAME OF CEMETERY or CREMATORY

Family Plot Cemetery

24D. LOCATION (City, town, or county)

Petersburg, Virginia

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 2 1971

Robert E. Farber, M.D.

Morton Dye & F.H. Mott

STILL IN

STILL IN

NO. 11

NO. 11

NO. 11

Handwritten signature and text at the bottom left, possibly "Horton" and "1944".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **71 11173**

BIRTH NO. **71 11173**

1. NAME OF DECEASED
(Type or Print)

JOHNSON, AMY HORTENCE

2. DATE AND HOUR OF DEATH

NOVEMBER 29, 1971 1:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION

**ST. AGNES HOSPITAL
WILKENS & CATON AVENUE
BALTIMORE, MD. 21229**

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2936 EDMONDSON AVE.

21223

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

09-01-14

9. AGE (In years
last birthday)

57

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CUSTODIAN

10B. KIND OF BUSINESS OR INDUSTRY

**DEPT. OF
EDUCATION**

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM JOHNSON

DEC 'D

14. MOTHER'S MAIDEN NAME

SARAH (KANE)

DEC 'D

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

2-7209057

17. INFORMANT

ADDRESS

ST. AGNES HOSPITAL, WILKENS & CATON AVE.

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Acute fulminant hepatitis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 weeks

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Hypertension

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **NOVEMBER 15** 19 **71** to **NOVEMBER 29** 19 **71**
that (I) (we) last saw the deceased alive on **NOVEMBER 29** 19 **71** and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jose Apter

DEGREE

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

11 29 71

23C. PHYSICIAN'S
NAME (Type)

JOSE APTER

23D. ADDRESS

CATON & WILKENS AVENUE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-4-71

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem Pk

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1971

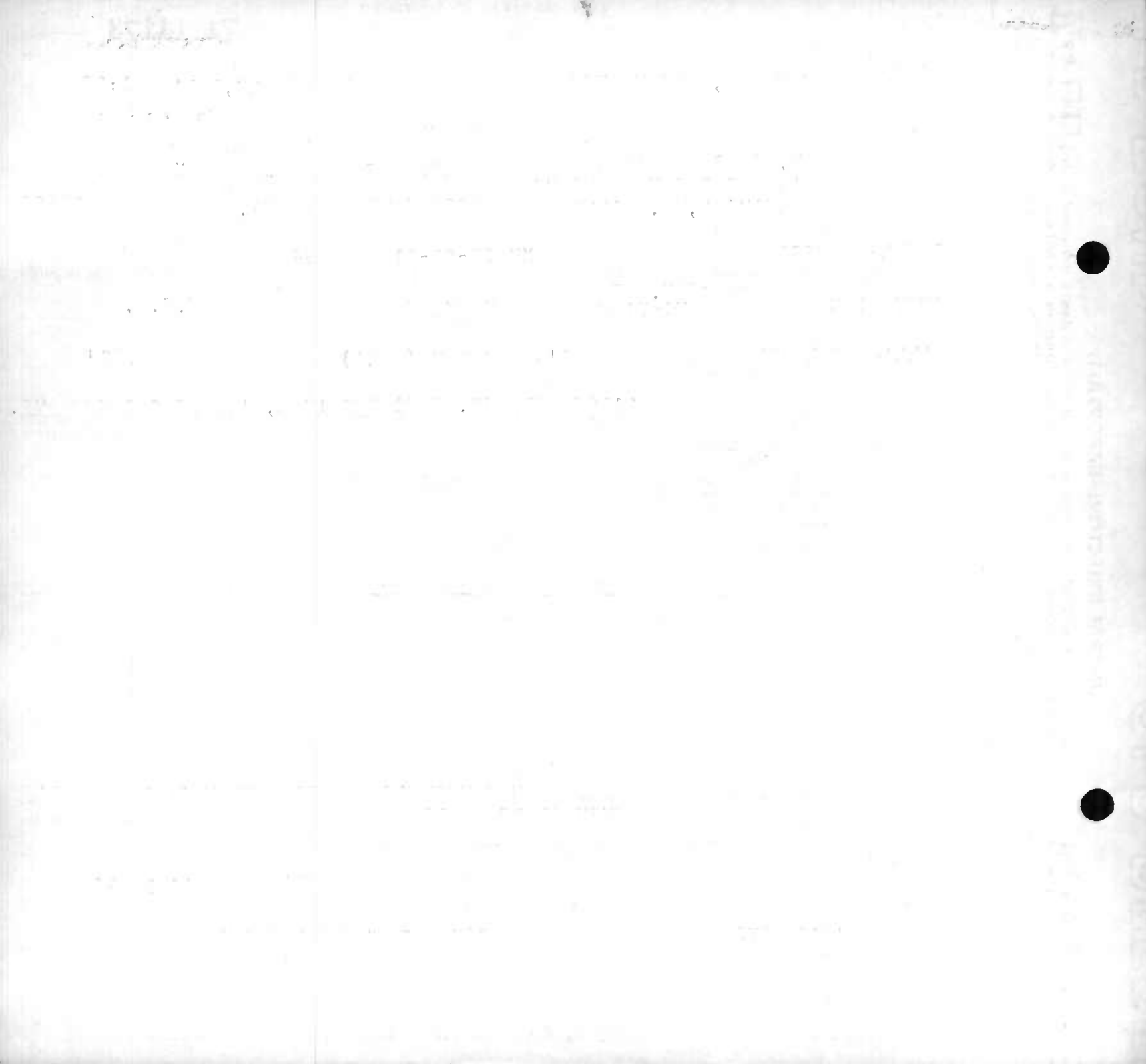
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Macfarlane, Dett F-H 1701-Hawkins

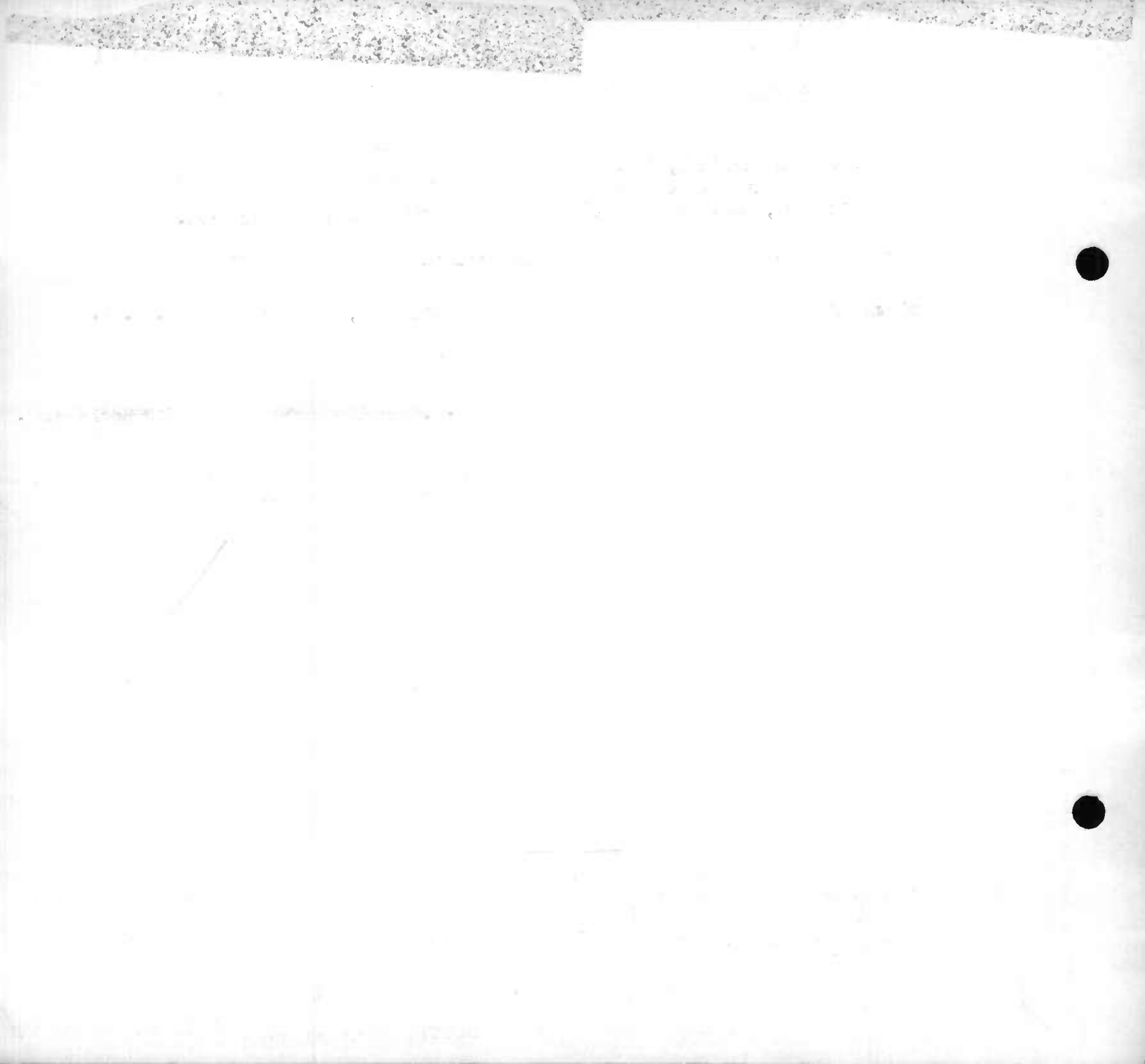
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>111174</u>	
BIRTH NO. <u>S 543 / 1 11174</u>		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH <u>Nov 30 1971 10:15 A.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>GOLDIE SMALLWOOD</u>		2. DATE AND HOUR OF DEATH <u>Nov 30 1971 10:15 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>2600 Liberty Heights Avenue</u> <u>Baltimore, Maryland 21215</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1538</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3603 Liberty Heights Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-17-19</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months: <u> </u> Days: <u> </u> If Under 24 Hrs. Hours: <u> </u> Min.: <u> </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machine operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Electons Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Smallwood</u>			
14. MOTHER'S MAIDEN NAME <u>Cora Thomas</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>218-09-0860</u>		17. INFORMANT ADDRESS <u>Mr. John Smallwood 2612 Foerster Avenue</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>(A) IMMEDIATE CAUSE: Co. of Rectum & wide spread metastasis.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u> </u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u> </u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u> </u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX) <u> </u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u> </u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 15 1971</u> to <u>Nov 30 1971</u> that (I) (we) last saw the deceased alive on <u>Nov 30 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rayman G. Alley MD</u>		23B. DATE SIGNED <u>Nov 30 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>Rayman G. Alley MD</u>	
23D. ADDRESS <u>Provident Hosp INC</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>12-4-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR ADDRESS <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

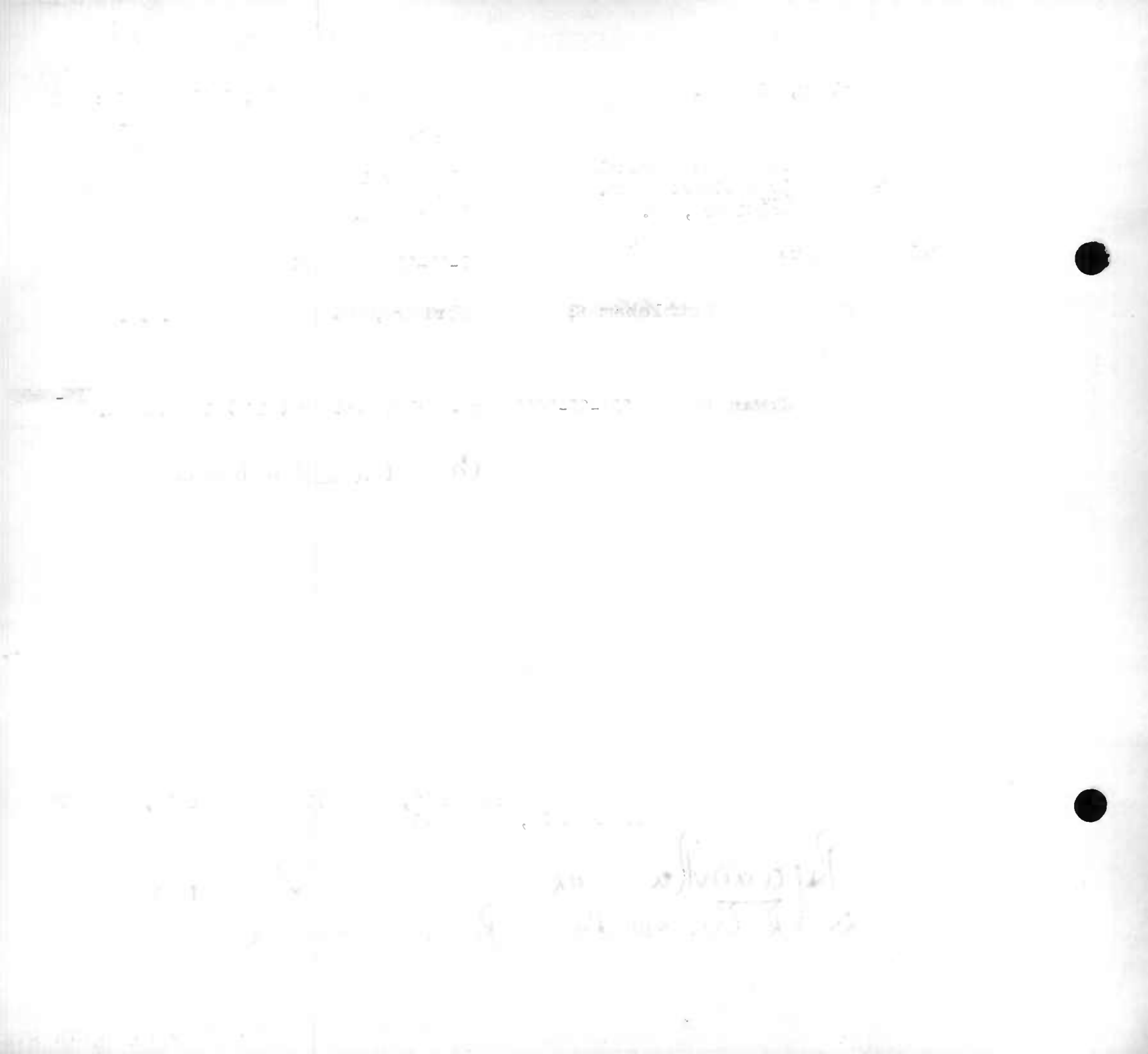
1. NAME OF DECEASED (Type or Print) Lucius A. Johnson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 30 71 8:30 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3308 Elgin Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 30 71 8:30 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-47	
9. DATE OF BIRTH 9-23-1897		10. AGE (In years lost birthday) 74	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaper		15. MOTHER'S MAIDEN NAME Isabelle ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I		17. SOCIAL SECURITY NO. 215-07-3431	
18. INFORMANT Mrs. Ida L. Johnson		ADDRESS 3308 Elgin Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21. AUTOPSY? (Yes or No) Yes	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 11-30-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-1971	
24C. NAME OF CEMETERY or CREMATORY Arbutus Meorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11176	
71 11176				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) Palmer, Floyd A.			2. DATE AND HOUR OF DEATH November 30, 1971 10:50 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Provident Hospital 2600 Liberty Hgts. Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY AA C. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1 Evans St.		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-23	9. AGE (in years last birthday) 48	10. Under 1 Tr. Months; Days 11. Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oiler -Crane			10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		
11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Palmer			14. MOTHER'S MAIDEN NAME Bertha ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II			16. SOCIAL SECURITY NO. 230-22-2643		
17. INFORMANT Mrs. Goldie Palmer (Wife)			ADDRESS 1 Evans St.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ca. Colon with metastasis					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 10, 1971 to November 30, 1971 that (I) (we) last saw the deceased alive on November 30, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rejoice M. R. Provinda RAO				23B. DATE SIGNED 11-30-71	
23C. PHYSICIAN'S NAME (Type) Dr. R. Provinda RAO				23D. ADDRESS Provident Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-71		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore Co. Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE			



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71 11177

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11177

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SAMUEL PRYOR JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year December 1, 1971 Hour 12:50 P.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1506			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-12-1915		10. AGE (In years lost birthday) 56	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burner Boston Iron & Metal		14B. KIND OF BUSINESS OR INDUSTRY Pauline Ford	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		17. SOCIAL SECURITY NO. 212-07-2521	
18. INFORMANT Mrs. Lucille Johnson		ADDRESS 2422 Presbury St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9661 X		CAUSE OF DEATH Gunshot wound of chest	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 12-6-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?	
22D. TIME OF INJURY (APPROX.) 11-28-71 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2300 Druid Hill Avenue		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12/1/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVE	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 11178	
CERTIFICATE OF DEATH				REG. NO. 71 11178	
BIRTH NO. 71 11178					
1. NAME OF DECEASED (Type or Print) WILLIAM GAINES		2. DATE AND HOUR OF DEATH 11/30/71 11:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MD B. COUNTY 1901			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL, 730 ASHBURTON ST, BALTO, MD 21216		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-18-01 9. AGE (In years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self-employed		10B. KIND OF BUSINESS OR INDUSTRY Taylor		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Lauvette Gaines		14. MOTHER'S MAIDEN NAME Sarah White			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Rogers G. Moore 1539 N. Payson St.	
18. 486 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASPIRATION PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DEHYDRATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from on 11/30/1971 and that (I) (we) last saw the deceased alive on 11/30/1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Arad Cader				23B. DATE SIGNED 12/1/71 12:15 AM	
23C. PHYSICIAN'S NAME (Type) AZAD CADER		23D. ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore Co. Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 2 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE			

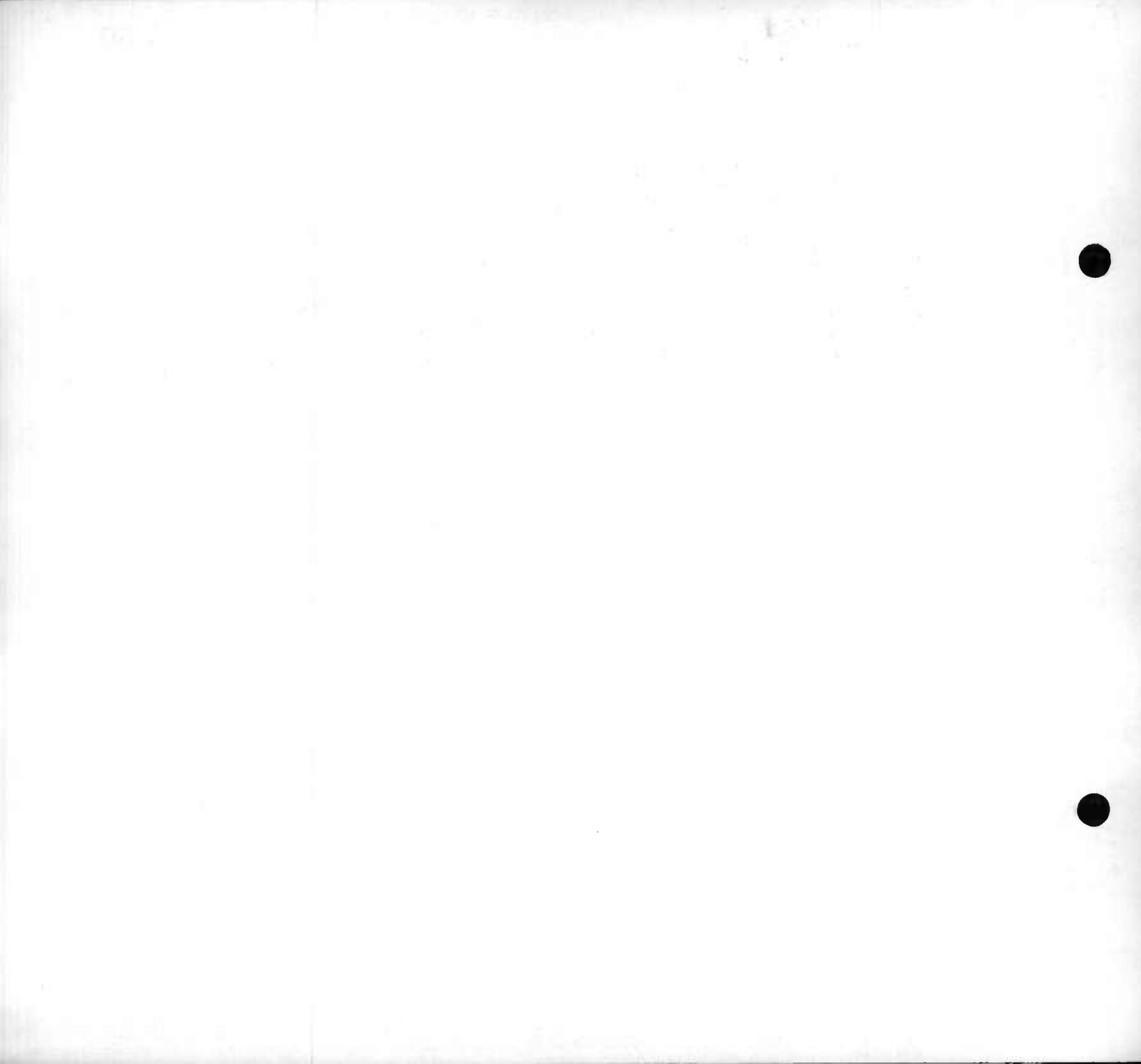
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11180	
71 11180				CERTIFICATE OF DEATH	
BIRTH NO. 71-19613		2. DATE AND HOUR OF DEATH 11/22/71 1.45 P.M.			
1. NAME OF DECEASED (Type or Print) BABY BOY RICHARDSON		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MD B. COUNTY 2833			
3. PLACE IN BALTIMORE/MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 Hospital Lombard & Green St		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-18-71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 4 1	
11. BIRTHPLACE (State or foreign country) Maryland - President Hosp		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME S S S S		14. MOTHER'S MAIDEN NAME Jessica A. Richardson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 276.9 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Poss. DIC		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Prematurity ? Infection. DUE TO, OR AS A CONSEQUENCE OF:		4 days	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/20/71 19 71 to 11/22 19 71 that (I) (we) last saw the deceased alive on 11/22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mayuree Khongcharoensuk M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/22/71	
23C. PHYSICIAN'S NAME (Type) MAYUREE KHONGCHAROENSUK, M.D.		23D. ADDRESS University Hosp. & Md. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) 11-22-71		24B. DATE		24C. NAME OF CEMETERY & CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 11181		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11181	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DULVALL, DOROTHY		2. DATE AND HOUR OF DEATH December 1, 1971 1 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY AA		5. SEX F 6. RACE Negro	
FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION State		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN ANNAPOLIS		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8. DATE OF BIRTH 1/22/20 9. AGE (In years last birthday) 51	
E. STREET AND NUMBER 2049 DRIVE		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME Thomas Howard		14. MOTHER'S MAIDEN NAME Sadie Mason		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Sadie H. Thompson-Anna, Md.	
18. 577.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart failure			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CHRONIC OF LIVER		4-5 yrs.	
		(C) Chronic alcoholism		15-20 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Chronic alcohol intoxication		20 yrs.	
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from October 27 1971 to December 1 1971 that (I) (we) last saw the deceased alive on December 1 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ming Kwei Liu M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-1-1971	
23C. PHYSICIAN'S NAME (Type) NING KWEI LIU, M.D.		23D. ADDRESS MONTEBELLO STATE HOSPITAL, BALTIMORE, MD			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/71		24C. NAME OF CEMETERY OR CREMATORY Adams	
24D. LOCATION Bayard A.A. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR William Reese, II - Anna, Md.		ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 11182

71 11182

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BABY BOY LANGLEY

2. DATE AND HOUR OF DEATH

11/19/71

2 47 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY OF MARYLAND HOSPITAL
38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

2004

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

309 Franklin town Rd

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

11/14/71

9. AGE (in years last birthday)

0

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JEROME HOUSE

14. MOTHER'S MAIDEN NAME

KOKEETA LANGLEY

309 Franklinton Rd.

Baltimore 21223

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

CHART

ADDRESS

18. 776.11

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

anoxia

DUE TO, OR AS A CONSEQUENCE OF:

(B) hyaline membrane disease, prematurity

DUE TO, OR AS A CONSEQUENCE OF:

(C) ad hyperbilirubinemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month, Day, Year, Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 14 1971 to Nov. 14 1971 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Magalnick M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/19/71

23C. PHYSICIAN'S NAME (Type)

H. MAGALNICK

M.D.

23D. ADDRESS

Univ. of Maryland Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

11-19-71

24C. NAME OF CEMETERY OR CREMATORY

ANATOMY BOARD OF MARYLAND

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 3 1971

25B. NAME OF REGISTRAR

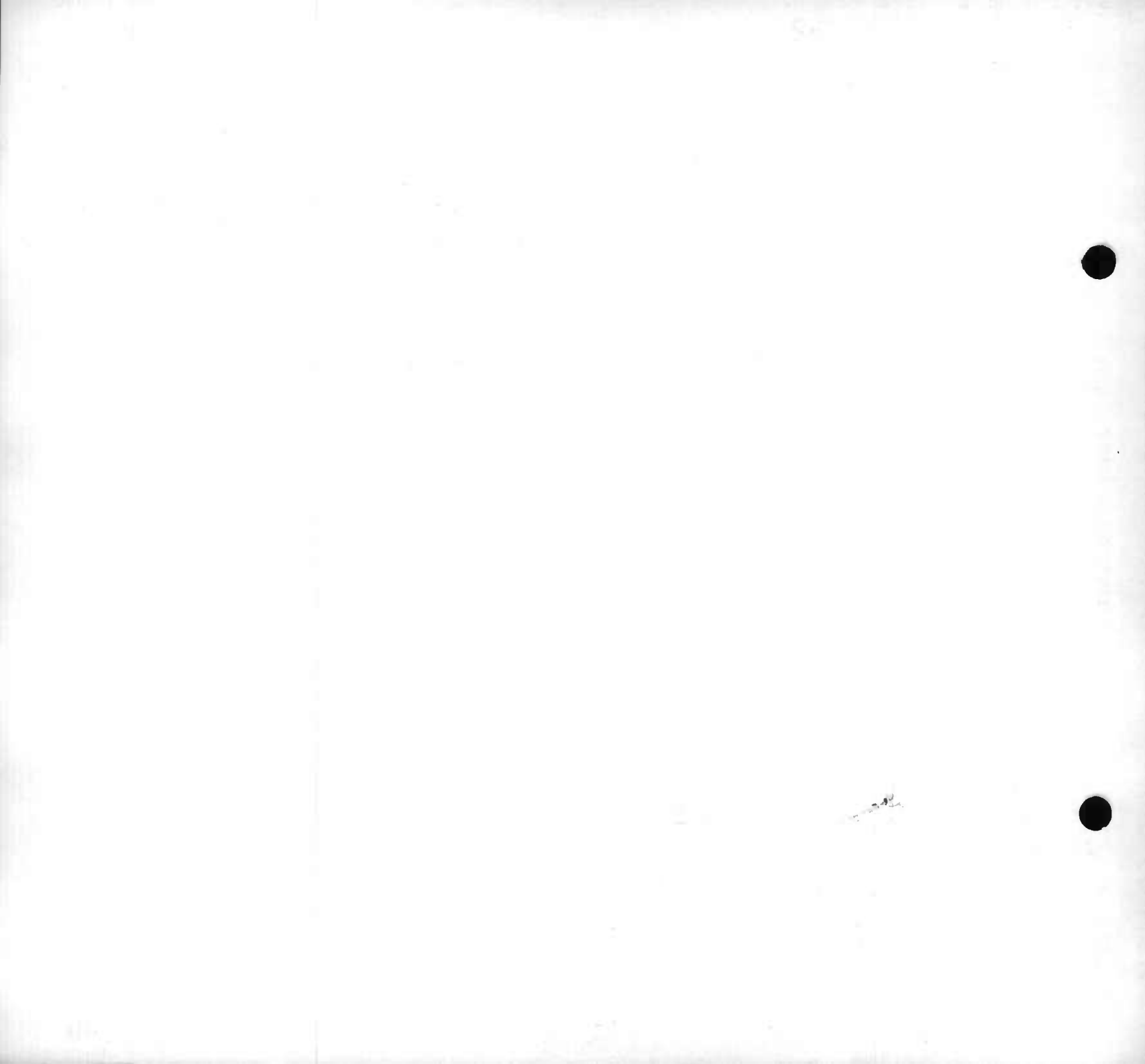
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

UNIVERSITY MORTUARY SERVICE

25D. ADDRESS

SCHOOL - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11183</u>
BIRTH NO. <u>71 11183</u> <u>11-11575</u>		1. NAME OF DECEASED (Type or Print) BABY GIRL SIMMS		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>12/18/71</u> <u>12 30</u> A.M.		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL GREENE ST.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BALTO.</u> B. COUNTY <u>M</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>MD.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>B</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <u>10/26/71</u>		9. AGE (In years last birthday) <u>22</u>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WILBUR SIMMS</u>		14. MOTHER'S MAIDEN NAME <u>BRENDA SIMMS</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE <u>HEMORRHAGIC DIATHESIS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>SEPTICEMIA</u> (B) <u>GANGRENOUS BOWEL, PERITONITIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>MALROTATION, MIDGUT VOLVULUS II</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>11/17</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GANGRENOUS BOWEL, PERFORATION</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> 19 <u>71</u> to <u>11/28</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>11/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>A. Stephen Dubansky M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/18/71</u>
23C. PHYSICIAN'S NAME (Type) <u>A STEPHEN DUBANSKY</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11-18-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHO</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 3 1971</u>		25B. NAME OF REGISTRAR <u>E. Fisher, R.D.</u>		25C. (For use of health department)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				TAMERA-B-42-82-95 REG. NO. 71 11184	
BIRTH NO. 71 11184		1. NAME OF DECEASED (Type or Print) BABY BOY ROBINSON		2. DATE AND HOUR OF DEATH 11/26/71 12:35 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital 38		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN 1303	
5. SEX M		6. RACE B		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 11/25/71	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) MARYLAND		9. AGE (In years last birthday) 1 12	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N		16. SOCIAL SECURITY NO.		17. INFORMANT TAMERA ROBINSON	
18. 776.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CARDIAC ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) SEVERE ASPHYXIA DUE TO, OR AS A CONSEQUENCE OF: (C) Respiratory Distress Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 36 hrs 36 hrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/25 1971 to 11/26 1971 that (I) (we) last saw the deceased alive on 11/26 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold Magalnick M.D.		23B. DATE SIGNED 11/26/71		23C. PHYSICIAN'S NAME (Type) HAROLD MAGALNICK M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-26-71		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF FUNERAL DIRECTOR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR'S ADDRESS UNIVERSITY OF MARYLAND HOSP. MORTUARY SERVICE - BCHD	

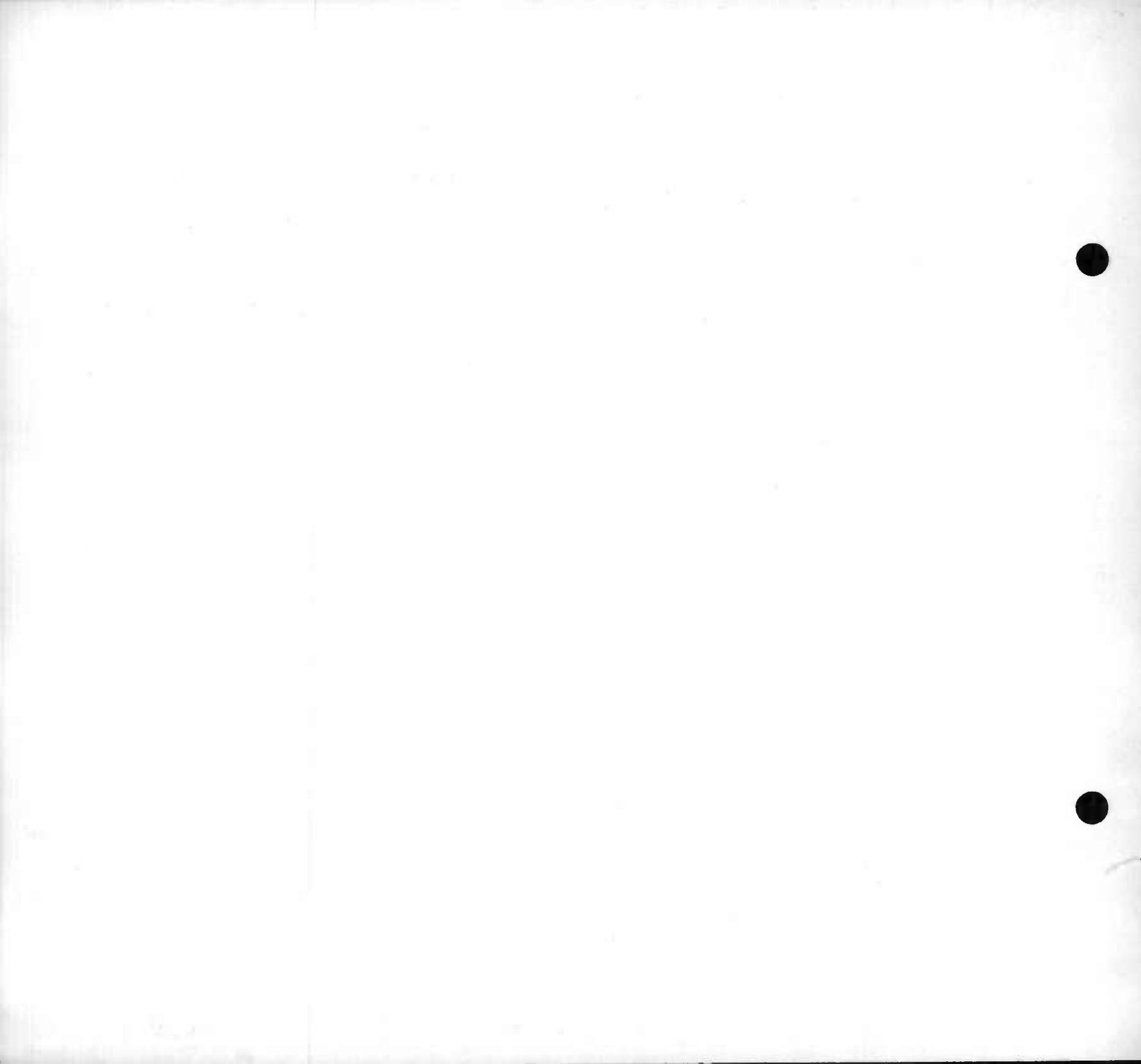
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11185

BIRTH NO. <u>71 11185 71-19460</u>		2. DATE AND HOUR OF DEATH <u>11-12-71</u> <u>12 A.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Swann</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1513</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. of Md. Hosp</u>		E. STREET AND NUMBER <u>2635 Quantic Ave #13</u>	
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-71</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		9. AGE (In years last birthday) <u>Newborn</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Univ. of Md. Hosp</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Swann</u>		14. MOTHER'S MAIDEN NAME <u>Ethelda Marlene Spivey</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory failure</u> <u>Primary atelectasis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Prematurity</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Anoxic seizure at delivery</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>A. Stephen Dubansky</u>		23B. DATE SIGNED <u>11/12/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. STEPHEN DUBANSKY</u>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11-12-71</u>	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Phyllis E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11186	
BIRTH NO. 71 11186		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Boy Johnson		2. DATE AND HOUR OF DEATH 11-8-71 4:15 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1603			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University of Md. Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 934 Gilmore ST			
5. SEX Male	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-71	9. AGE (in years last birthday) 4	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Maryland	
13. FATHER'S NAME Milton Hunter		14. MOTHER'S MAIDEN NAME Hilda Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT 934 Gilmore	
18. 776.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Respiratory distress syndrome		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 15 min.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 11/8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/7 19 71 to 11/8 19 71 that (I) (we) last saw the deceased alive on 11/8 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mayuree Khongcharoensuk M.D.		23B. DATE SIGNED 11/8/71		23C. PHYSICIAN'S NAME (Type) MAYUREE KHONGCHAROENSUK M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-8-71		24C. NAME OF CEMETERY, CREMATORY University Hosp. Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>71 11187</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 71 11187</p>			
<p>BIRTH NO. 71 11187</p> <p>1. NAME OF DECEASED JOSEPH PETER A. HELINSKI</p> <p>(Type or Print)</p>		<p>2. DATE AND HOUR OF DEATH 11/30/71 6:00 p.m.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>CERTIFICATE AMENDED</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES GEN. HOSP.</p> <p>(If not in hospital or institution, give street address or location)</p> <p>12-27-71</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY BALTO</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 1736 LESLIE RD.</p>	
<p>5. SEX MALE</p> <p>6. RACE WHITE</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 12/10/98</p> <p>9. AGE (in years last birthday) 73</p>	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tin Cutter</p> <p>10B. KIND OF BUSINESS OR INDUSTRY Can MFG.</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p> <p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME THOMAS HELINSKI</p>		<p>14. MOTHER'S MAIDEN NAME SOFIA GSOBUS</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>yes WW 1</p>		<p>16. SOCIAL SECURITY NO. 215-09-6141</p>	
<p>17. INFORMANT Gloria Berryman</p> <p>ADDRESS 1321 Bunsen Way 21224</p>			
<p>18. 199.1 I</p> <p style="text-align: center;">CAUSE OF DEATH</p> <p style="text-align: center;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 11/29/71</p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) NO</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p> <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 11/29 19 71 to 11/30 19 71</p> <p>that (I) (we) last saw the deceased alive on 11/30 6:00 p.m. 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE [Signature]</p> <p>23C. PHYSICIAN'S NAME (Type) AGATON H. ESCOBARTE, M.D.</p> <p>DEGREE</p>		<p>23B. DATE SIGNED 11/30/71</p> <p>23D. ADDRESS NORTH CHARLES GEN. HOSP.</p> <p>DEGREE</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 12/4/71</p>	<p>24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus</p>	<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Sabay, M.D.</p>	
<p>25C. FUNERAL DIRECTOR M. F. SADOWSKI & SONS, 1808 EASTERN AVE</p> <p>ADDRESS</p>			

V.S. 153

12-27-71

M.H.

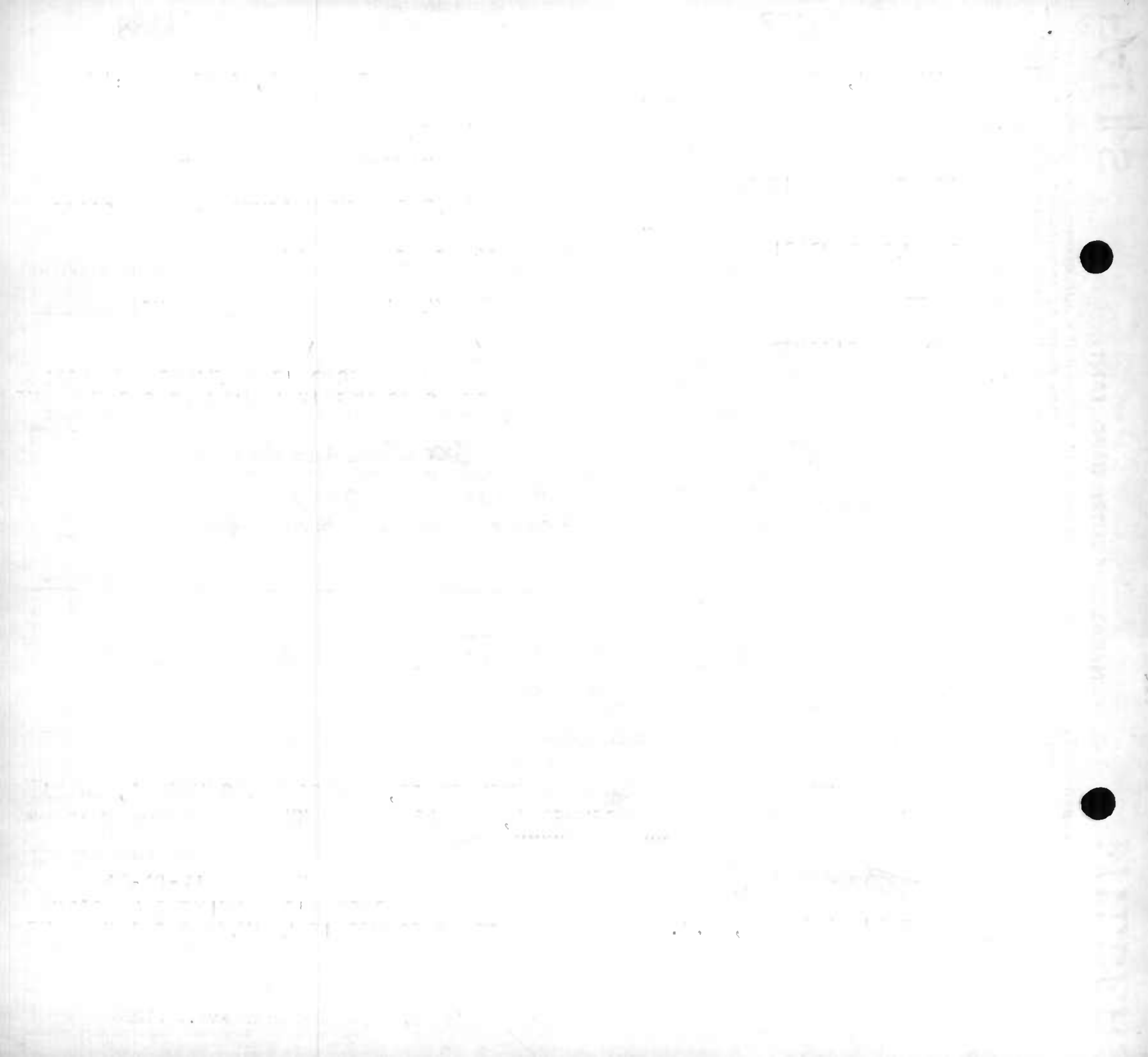
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11188

BIRTH NO. 71 11188		1. NAME OF DECEASED (Type or Print) SHANLEY, EMMA		2. DATE AND HOUR OF DEATH DECEMBER 1, 1971 6:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2007 FOREST HEIGHTS DR 21207	
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04 25 95	9. AGE (In years last birthday) 76	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME BERNARD FISCHER		14. MOTHER'S MAIDEN NAME (Fena)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 430.9 I CAUSE OF DEATH CEREBRO VASCULAR ACCIDENT. Most probably SUB ARACHNOID HEAMMORHAGE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 30, 19 71 to DECEMBER 1, 19 71 that (X) (we) lost saw the deceased alive on DECEMBER 1, 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE TARIQ MAHMOOD, M.D.		23B. DATE SIGNED 12-01-71		23C. PHYSICIAN'S NAME (Type) TARIQ MAHMOOD, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/71		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson ave., 21228		25D. ADDRESS RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			



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8650

71-11189

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11189

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES R. GREEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2515 Quantico Avenue		3. DATE PRONOUNCED DEAD Month Day Year November 30, 1971 Hour 9:50 P.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6-24-05		10. AGE (In years lost birthday) 66 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME JENNETTE PURYEAR		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 216-01-7741		18. INFORMANT MARGARET FOOTE - 2515 QUANTICO AVE	
19. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) DATE SIGNED 12/1/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/4/71	
24C. NAME OF CEMETERY or CREMATORY GARDEN OF ETERNAL HOME		24D. LOCATION (City, town, or county) (State) FINKSBURG MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR EARL GALMORE		ADDRESS 1827 W. NORTH AVE	

1183

6-24-62

MERRIS GREEN

U.S.

NORTH CAROLINA

DEPARTMENT OF

REVENUE

210-01-101 MARSHALL

NO

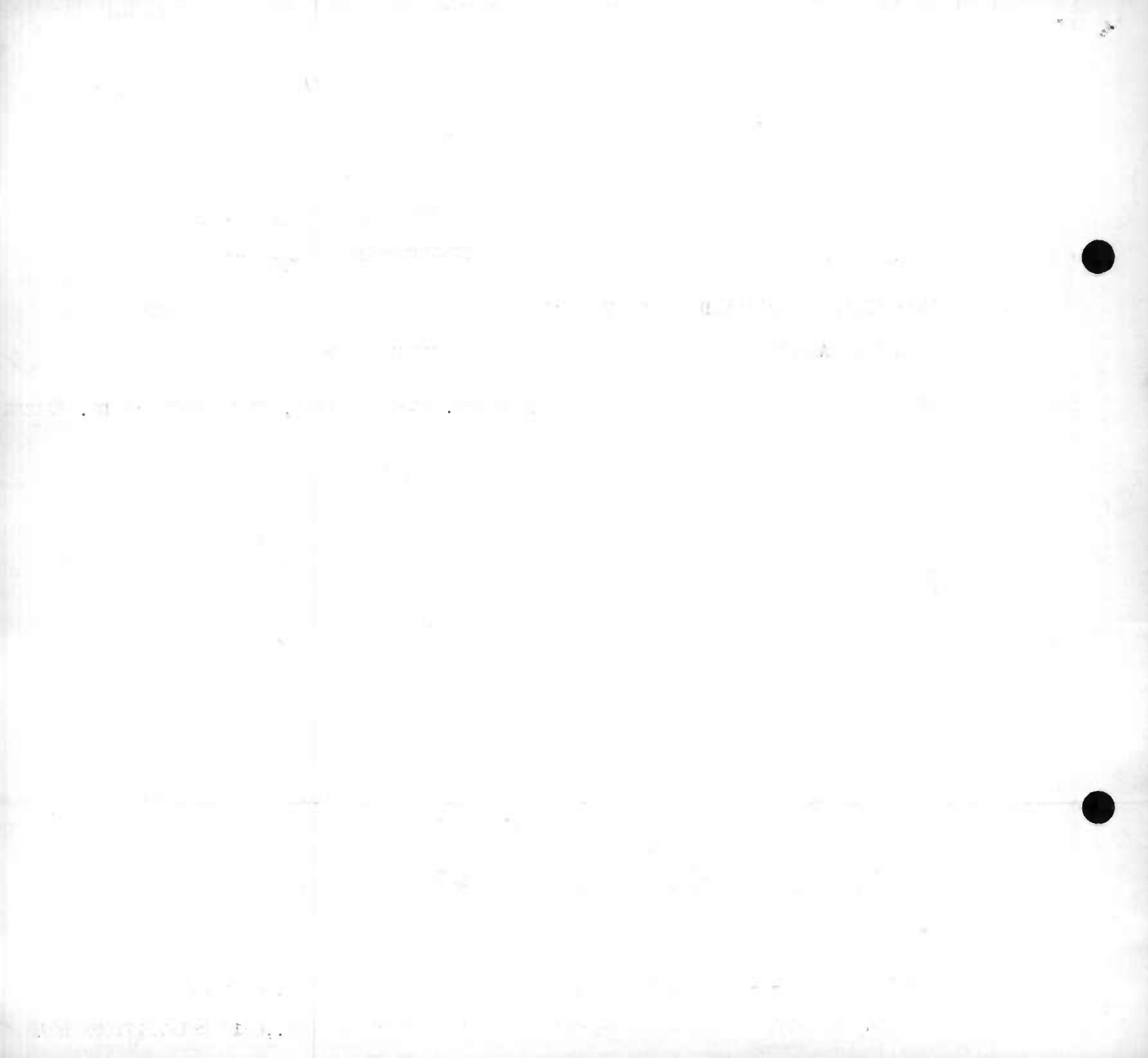
Return to: 1183

1183

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11190	
BIRTH NO. 71 11190		2. DATE AND HOUR OF DEATH 11-30-71 12³³ PM	
1. NAME OF DECEASED (Type or Print) Albert M. PASSEN		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTO	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL Hospital 48		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3707 PARKFIELD AVE.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX 9. AGE (in years last birthday) 75
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED GROCERY STORE		11. BIRTHPLACE (State or foreign country) Russia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SOLOMON PASSEN		14. MOTHER'S MAIDEN NAME FAIGA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-18-3634 17. INFORMANT ADDRESS MRS. FLORENCE LITT, 3707 PARKFIELD DR. #21208	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 + 1 250.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus Chronic bronchitis + emphysema		(A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: Post op left upper lobectomy (B) for giant cell Ca of lung DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown 1958	
19A. DATE OF OPERATION 11-30-71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of lung		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from 11-12 19 71 to 11-30 19 71 that (X) (we) last saw the deceased alive on 11-30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Michael P. Buchness M.D.		23B. DATE SIGNED 11-30-71	
23C. PHYSICIAN'S NAME (Type) Michael P. Buchness M.D.		23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-1-71	
24C. NAME OF CEMETERY OR CREMATORY BNAI JACOB		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Talley, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6000 REISTERSTOWN ROAD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

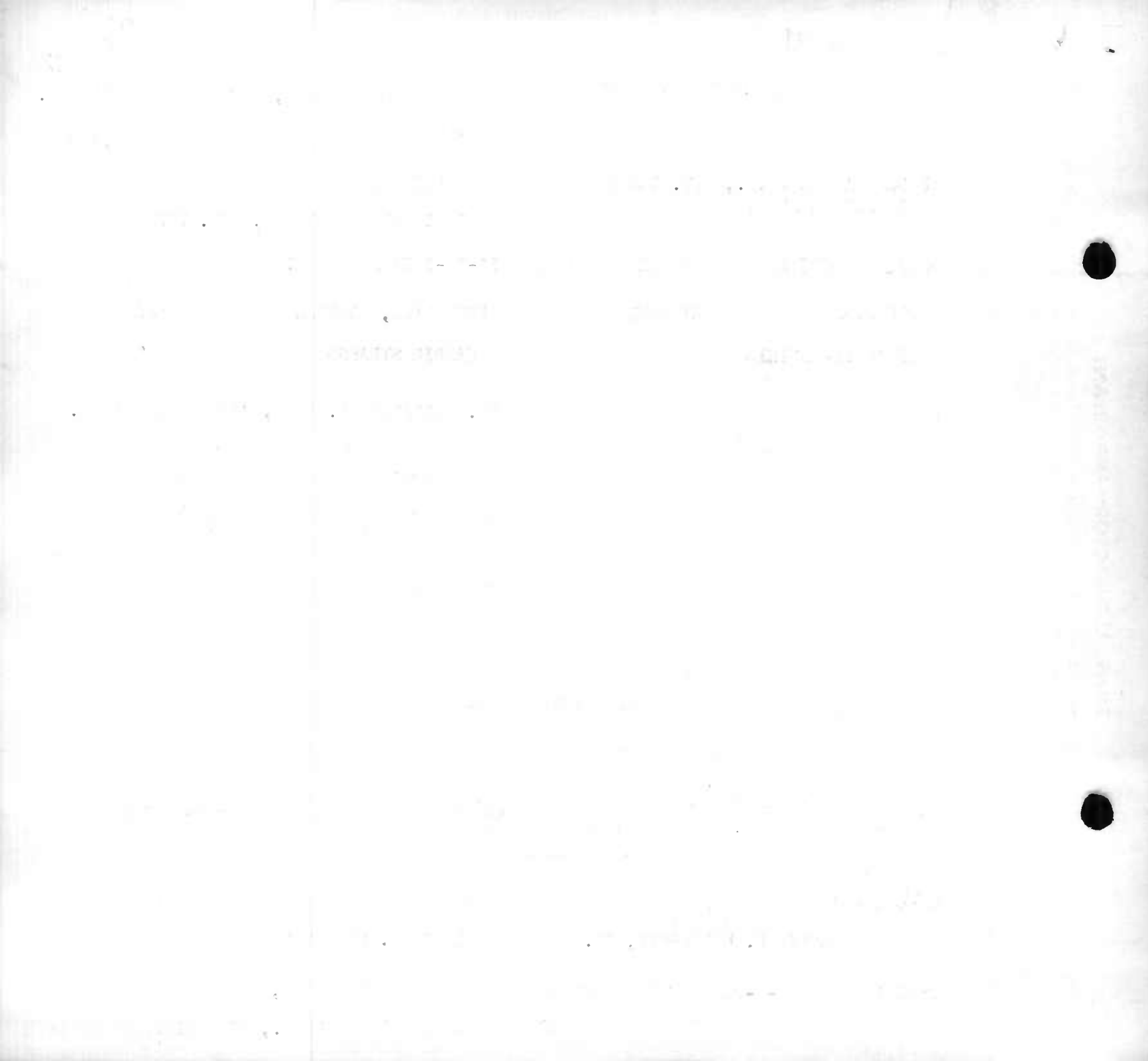
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **71 11191**

BIRTH NO. **71 11191**

1. NAME OF DECEASED (Type or Print) MELIA LOWENSTEIN HAMBURGER		2. DATE AND HOUR OF DEATH NOVEMBER 30, 1971 10 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) TEMPLE GARDEN APTS., APT. 705 C 2601 MADISON AVENUE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1301	
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2601 MADISON AVENUE, APT. 705C	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1874
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 97
11. BIRTHPLACE (State or foreign country) FREDERICKY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC LOWENSTEIN		14. MOTHER'S MAIDEN NAME CARRIE STRAUSS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT DR. ELIZABETH C. LANE, 214 KNOLLWOOD DR.		ADDRESS	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) Anterior wall heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic congestive heart failure Generalized arteriosclerosis			
CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/28/71 to 11/30/71 that (I) (we) last saw the deceased alive on 24 November 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Louis P. Hamburger, Jr.		23B. DATE SIGNED 11/30/71	
23C. PHYSICIAN'S NAME (Type) LOUIS P. HAMBURGER, JR.		23D. ADDRESS 1001 ST. PAUL STREET	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-2-71	
24C. NAME of CEMETERY or CREMATORY HEBREW FRIENDSHIP		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



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BALTIMORE CITY HEALTH DEPARTMENT

71 11192

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11192

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PHILIP SANDLER

2. DATE
OF
DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

42 SINAI HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

2:30 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2720

6. SEX

Male

7. RACE

White

8. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

9. DATE OF BIRTH

JUNE 15, 1905

10. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3811 Glengyle Avenue

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

MORRIS SANDLER

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CHAUFFEUR

14B. KIND OF BUSINESS OR INDUSTRY

CITY OF BALTIMORE

15. MOTHER'S MAIDEN NAME

SARAH ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

W.W. II

17. SOCIAL
SECURITY NO.

213-14-4900

18. INFORMANT

ADDRESS

MRS. MOLLIE SANDLER, 3811 GLENGYLE AVE. #21215

19. E 814-7

CAUSE OF DEATH

Multiple traumatic injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Glengyle and Leist Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) November 1971 ?

22E. INJURY OCCURRED
WHILE AT WORK ☐

NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by car

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/1/71

24A. BURIAL CREMATION,
REMOVAL (Specify)
BURIAL

24B. DATE

12-2-1971

24C. NAME of CEMETERY or CREMATORY

SHAAREI ZION

24D. LOCATION (City, town, or county)

(State)

ROSEDALE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

DEC 3 1971

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

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SPRING 1963

JOHN G. GILBERT

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JOHN G. GILBERT

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CITY OF BIRMINGHAM

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11193	
BIRTH NO. 71 11193 1. NAME OF DECEASED (Type or Print) ISRAEL GERSUK		2. DATE AND HOUR OF DEATH NOVEMBER 30, 1971 9:40 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JEWISH CONVALESCENT HOME 4600 PALL MALL ROAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3814 NORFOLK AVENUE #21216			
5. SEX MALE 6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 7, 1884 9. AGE (In years last birthday) 87 If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY GROCERY STORE		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME MOSES GERSUK		14. MOTHER'S MAIDEN NAME IDA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 427-26-3798		17. INFORMANT CAPT. IPSEY JEROME GERSUK, MC LEAN, VA. 22101	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE CHF & Pulmon. Edema DUE TO, OR AS A CONSEQUENCE OF: A SHD & Atrial Fibrillation (B) DUE TO, OR AS A CONSEQUENCE OF: Asthma & Bronchitis (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 12 years 12 years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/15/65 19 to 11/30/71 19, that (I) (we) last saw the deceased alive on 11/30 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Israel Zinberg				23B. DATE SIGNED 12/1/71	
23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG				23D. ADDRESS 4000 W. NORTHERN PKWY.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-2-71		24C. NAME OF CEMETERY or CREMATORY BOBROISKER BENEFICIAL CIRCLE	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

11/13/52

RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: Mr. C. H. ...
FROM: Mr. ...
SUBJECT: ...

11/13/52

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71 11194

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11194

BIRTH NO.

1. NAME OF DECEASED (Type or Print) T. Mathew Harris		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 11 30 71 Hour 7:06 A. M.	
4. PLACE IN BALTIMORE, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2550 W. Fayette Street		3. DATE PRONOUNCED DEAD Month Day Year 11 30 71 Hour 7:06 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH OCT 30 1904		10. AGE (In years lost birthday) 67	
11. BIRTHPLACE (State or foreign country) Gloucester Co VA		12. CITIZEN OF USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		15. MOTHER'S MAIDEN NAME ANNIE FIELDS	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 218-03-6410	
18. INFORMANT Virgie Gouardine 2550 Fayette St		ADDRESS	
19. CAUSE OF DEATH 412.41		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/4/71	
24C. NAME OF CEMETERY or CREMATORY MT AUBURN		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wortham & Sons		ADDRESS 635 N. G. L. M. St.	

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11195

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Lucile M. Taylor		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 2 Year 71 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1058 Argyle Ave. - Apt. 3F		3. DATE PRONOUNCED DEAD Month 12 Day 2 Year 71 Hour 6:15 a.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Jan 1916		10. AGE (In years lost birthday) 55	
11. BIRTHPLACE (State or foreign country) MANNING S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		15. MOTHER'S MAIDEN NAME MATHILDA	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT ADDRESS Louise Wright 1058 Argyle Ave		19. 412.21	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Hypertension and Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/4/71	
24C. NAME of CEMETERY or CREMATORY Family Plot		24D. LOCATION (City, town, or county) (State) CHARLESTON S.C.	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	

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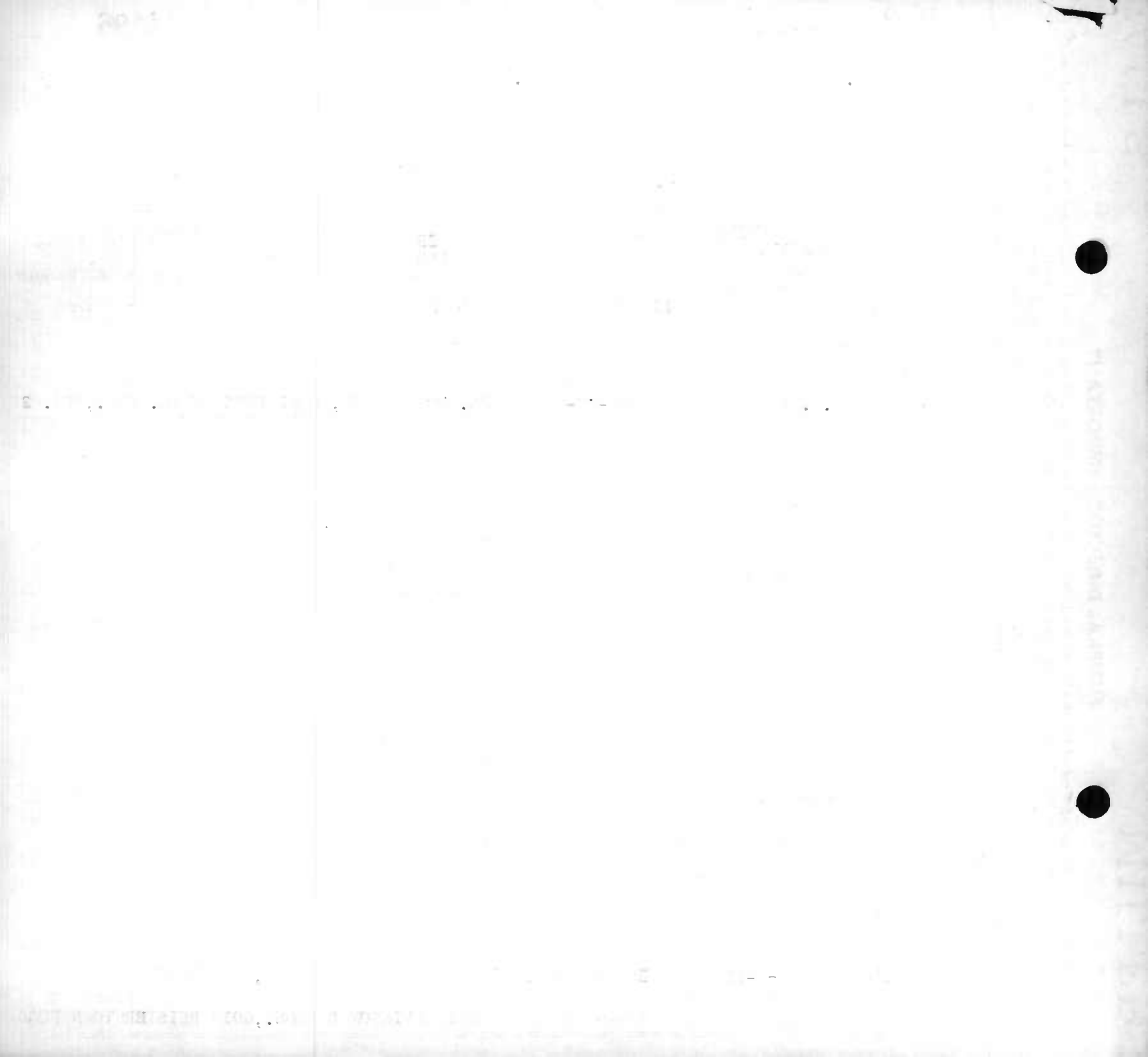
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11196	
BIRTH NO. 71 11196		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) M. JACOB ROUND (MOSES J.)		2. DATE AND HOUR OF DEATH 12-1-71 1:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE INC		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2740 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6001 PARK HEIGHTS AVE #15	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY LIQUOR	9. AGE (In years last birthday) 78
13. FATHER'S NAME ZVI ROUND		14. MOTHER'S MAIDEN NAME PESSE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I		16. SOCIAL SECURITY NO. 219-14-1805A	
17. INFORMANT MRS. ROSE ROUND, 6001 PARK HEIGHTS, AVE., APT. 2F		ADDRESS	
18. 410.9 153.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: TION		35 DAYS	
(B) CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF:		20 YEARS	
(C) ATHEROSCLEROTIC HEART DISEASE		30 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CARCINOMA OF THE COLON (RESECTED)		1 1/2 YEARS	
19A. DATE OF OPERATION 11-20-71	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LIVER BIOPSY TO	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10-10-71 to 12-1-71 that (1) (we) last saw the deceased alive on 12-1-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE GUTIERREZ		23B. DATE SIGNED 12-1-71	
23C. PHYSICIAN'S NAME (Type) FELIX GUTIERREZ M.D.		23D. ADDRESS SINAI HOSPITAL OF BALTO INC.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12-2-71	24C. NAME of CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD



FUNERAL DIRECTOR: IMPORTANT

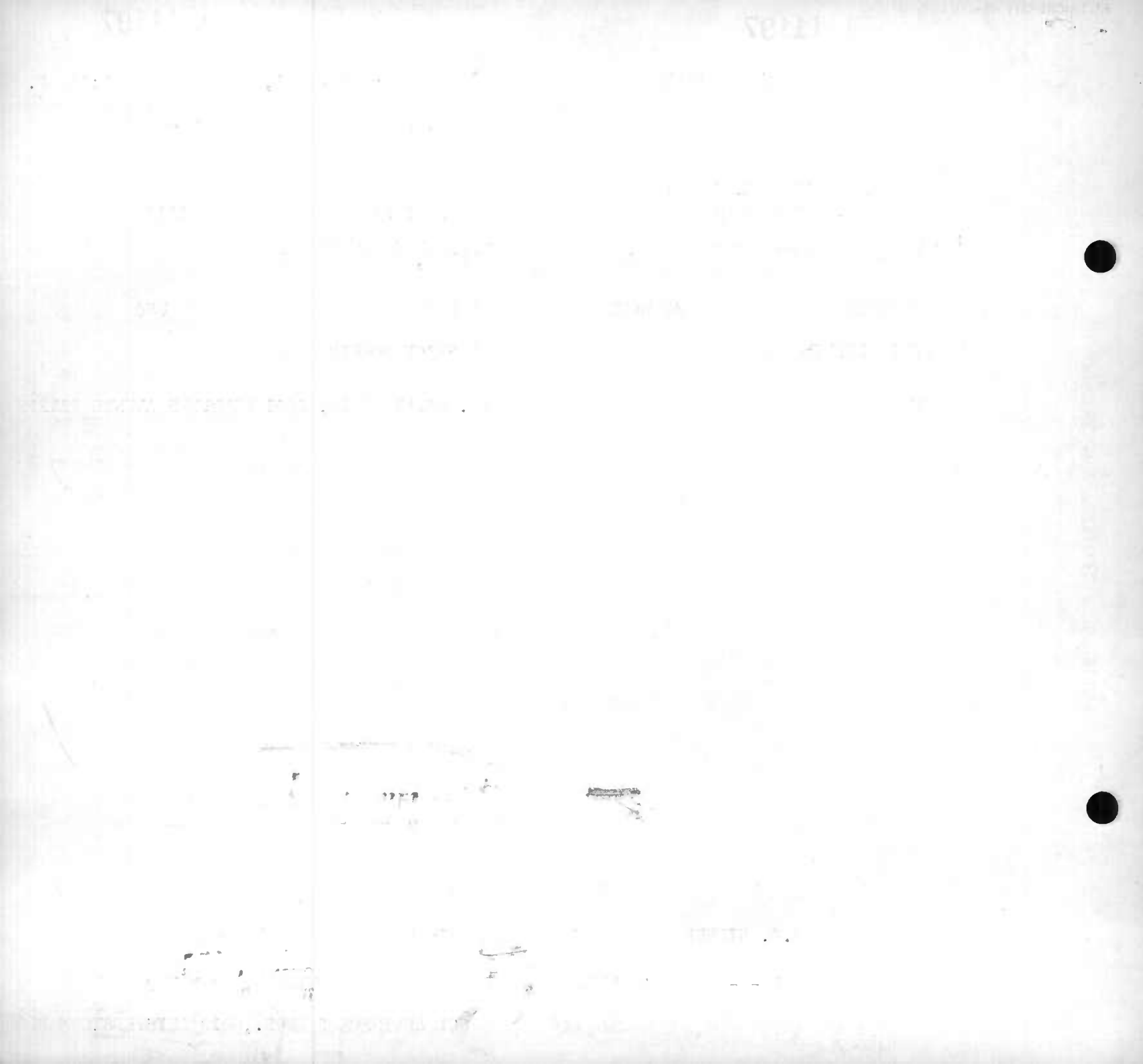
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

130 71 11197

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11197

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PAULINE LEVITT		DECEMBER 1, 1971 7:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
JEWISH CONVALESCENT HOME 4601 PALL MALL ROAD				MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5901 SIMMONDS AVENUE #21215	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE		JULY 2, 1884	87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		RUSSIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
DAVID ZELDIN			STACY ROBKin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				DR. HARRY RUDIN, 5901 SIMMONDS AVENUE #21215	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Pneumonia 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Chronic Brain Damage 5 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 9, 1971 to Dec. 1, 1971, that (I) (we) last saw the deceased alive on Dec. 1, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. A. Silver				23B. DATE SIGNED Dec. 4, 1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
A. A. SILVER				6210 PARK HEIGHTS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-2-71		BETH TFILOH	
				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 3 1971		Robert E. Farber, R.D.		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



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BALTIMORE CITY HEALTH DEPARTMENT

71 11198

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11198

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James E Ourand		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 29 71 7:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 29 71 7:45 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Reisterstown Baltimore	
9. DATE OF BIRTH April 13, 1927 44		10. AGE (In years lost birthday) 44	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Manager Black & Decker Co.		15. MOTHER'S MAIDEN NAME Catherine Morris	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 220-12-3483	
19. 412.4 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes		18. INFORMANT 126 Cherry Valley Rd., Mary Ourand Reisterstown, Md.	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-30-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 2, 1971	
24C. NAME OF CEMETERY or CREMATORY Evergreen Mem. Gardens		24D. LOCATION (City, town, or county) (State) Finksburg, Carroll, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR H. J. Schmitt		ADDRESS Owings Mills, Md.	

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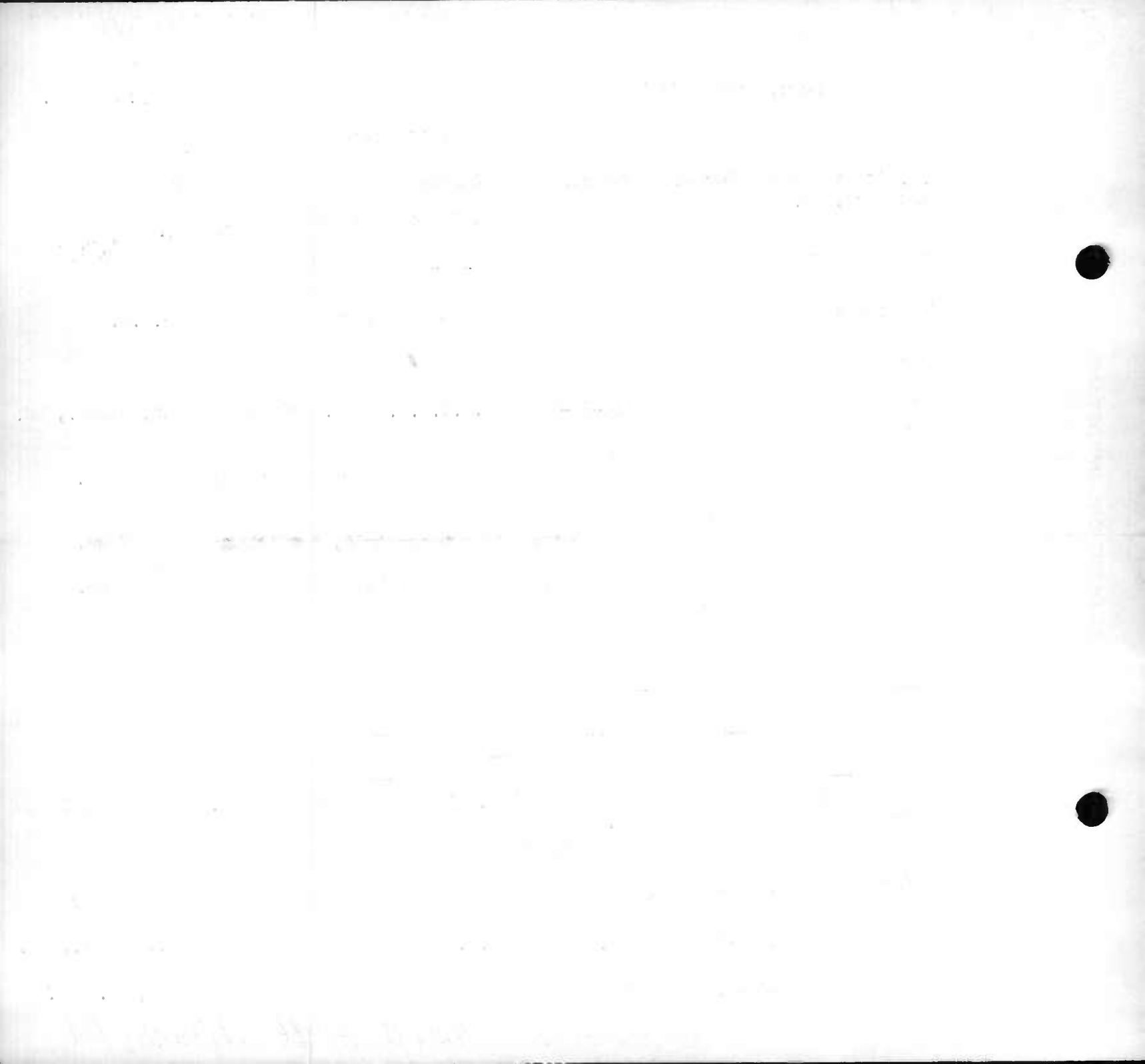
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11199	
BIRTH NO. 71 11199		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Emmart, Opal Madeline		2. DATE AND HOUR OF DEATH 11/30/71 3:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE West Virginia B. COUNTY V45	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) U.S. Public Health Service Hospital Baltimore, Md.		C. CITY OR TOWN Romney	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 359 North Marsham Street	
5. SEX Female	6. RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-16
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 55
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Arnold		14. MOTHER'S MAIDEN NAME Ivy Moreland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 234-38-7995	
		17. INFORMANT U.S.P.H.S. Hosp. Medical Records, Balto., Md.	
18. 205.01 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Acute bronchopneumonia, ? etiology DUE TO, OR AS A CONSEQUENCE OF: (B) acute myelogenous leukemia DUE TO, OR AS A CONSEQUENCE OF: (C) diabetes mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 da. 7 da. 1 YR. 8 mo. 6 mo. Rev ?	
19. DATE OF OPERATION 0---		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ---	
20A. AUTOPSY? (Yes or No) ---		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ---	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ---		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---		21D. TIME OF INJURY (APPROX.) ---	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---	
22. I certify that (H) (this hospital) attended the deceased from Nov. 23 19 71 to Nov. 30 19 71 and that (H) (we) last saw the deceased alive on Nov. 30 19 71 and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (not) view the body after death.			
23A. SIGNATURE Robert R. Wright, M.D.		23B. DATE SIGNED 11-30-71	
23C. PHYSICIAN'S NAME (Type) Robert R. Wright, M.D.		23D. ADDRESS U.S. Public Health Service Hosp., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-3-71	24C. NAME OF CEMETERY or CREMATORY Levels Cemetery	24D. LOCATION (City, town, or county) (State) Levels, W. Va.
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971	25B. NAME OF REGISTRAR Robert E. Jaber, M.D.	25C. FUNERAL DIRECTOR Harry W. Haight	ADDRESS Sylasville, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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71 11200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11200

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>T. MARTIN GANNON</u>		2. DATE AND HOUR OF DEATH <u>11-30-71</u> <u>1</u> <u>330</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1305</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 MONTE BELLO STATE HOSP.</u>		E. STREET AND NUMBER <u>2911 KESWICK Rd. 212 11</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-05-07</u>	9. AGE (in years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retail store</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>William GANNON</u>		14. MOTHER'S MAIDEN NAME <u>Catherine</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216128973</u>		17. INFORMANT ADDRESS <u>MARGARET Redmiles 3728 Elm Av</u>	
18. <u>162.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>CARCINOMA OF (R) LUNG</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PULMONARY EMPHYSEMA</u> <u>EMPYEMA R. PLEURAL CAVITY</u>					
19A. DATE OF OPERATION <u>311-24-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA OF (R) LUNG</u>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-4</u> 19 <u>71</u> to <u>11-30</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>11-30</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Elsa M. Goris</u>				23B. DATE SIGNED <u>11-30-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ELSA M. GORIS</u>		23D. ADDRESS <u>Burgess Funeral Home Balto Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4 Dec 71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Burgess Funeral Home Balto Md</u>	
25D. ADDRESS					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11201	
BIRTH NO. 71 11201		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DISTEFANO, MARY LILLIAN		2. DATE AND HOUR OF DEATH NOVEMBER 29, 1971 5:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		A. STATE MARYLAND		B. COUNTY HOWARD 21043	
C. CITY OR TOWN ELICOTT CITY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 8118 WOODVIEW ROAD		6300			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/12/99	9. AGE (In years last birthday) 72	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY Car Loading		11. BIRTHPLACE (State or foreign country) MARYLAND - Balto.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME AUGUST CATANZARO		14. MOTHER'S MAIDEN NAME ANNA Purpura	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 217-05-1182		17. INFORMANT BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia, sepsis		+ 3 days	
		(B) DUE TO, OR AS A CONSEQUENCE OF: anaemia, a70 leucemia, plural effusion		+ 1 year	
		(C) malignant hypertension			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Limited autopsy	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from NOVEMBER 23 19 71 to NOVEMBER 29 19 71 that (X) (we) lost saw the deceased alive on NOVEMBER 29 19 71 and that (the) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE 77. Mol.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) JACOBUS MOL, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/2/71		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery, Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Jacobus, R.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS Leading Funeral Estate, 736 Edmondson Ave., Catonsville, Md. 21228			

Letter from St. Agnes Hospital
12-9-71 M.H.

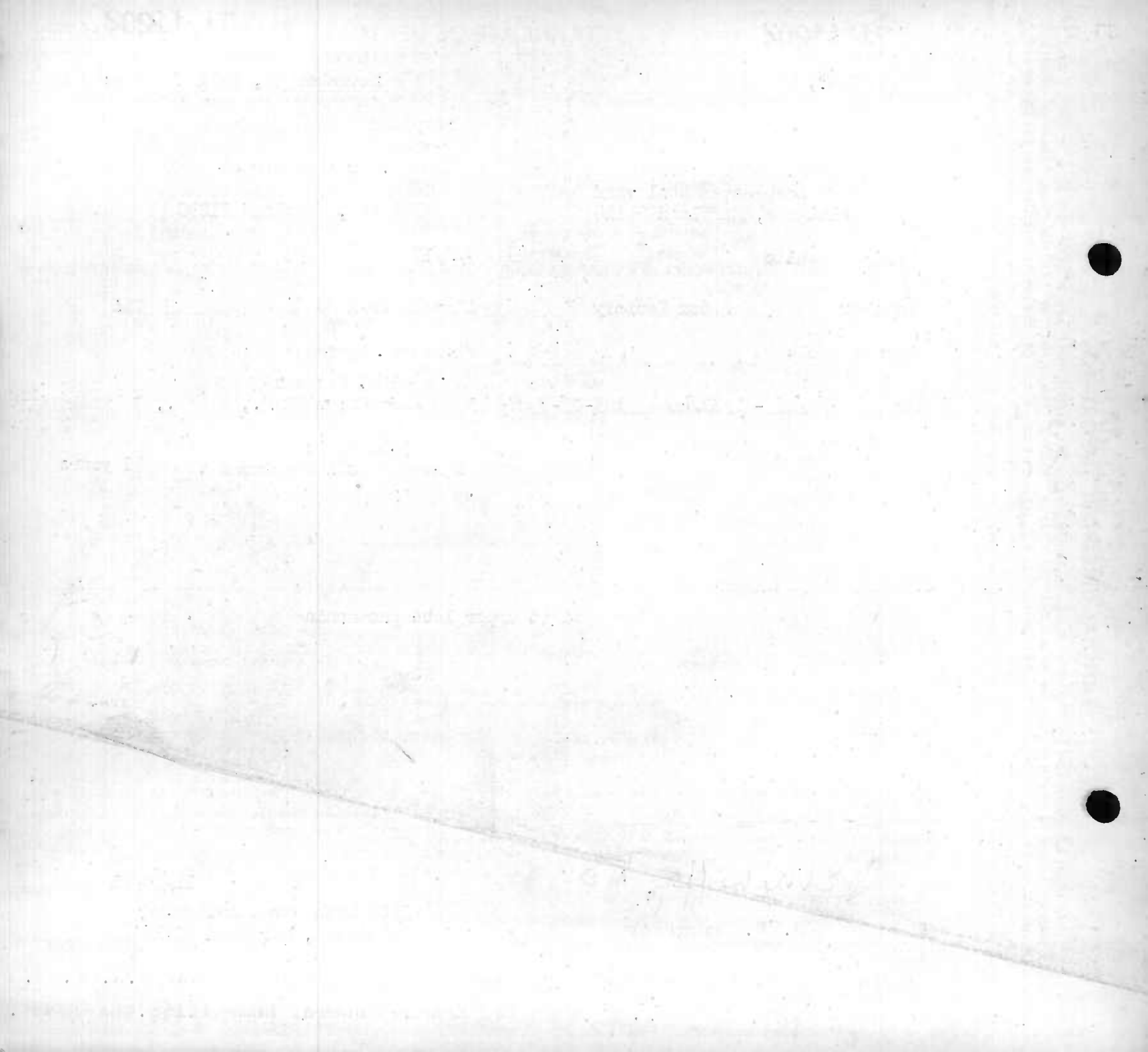
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. **71 11202**

BIRTH NO. **71 11202**

1. NAME OF DECEASED (Type or Print) HICKS, HARRY W		2. DATE AND HOUR OF DEATH November 29, 1971 9:45 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2301 C. CITY OR TOWN 1208 S. Hanover Street D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Baltimore, Maryland 21230	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/15
9. AGE (In years last birthday) 56		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Box factory	
11. BIRTHPLACE (State or foreign country) Lincoln Park NJ		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther Hicks		14. MOTHER'S MAIDEN NAME Florence Simpson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/6/45 - 1/31/46		16. SOCIAL SECURITY NO. 148-05-8047	
17. INFORMANT VA Hospital Records		ADDRESS 3900 Loch Raven Blvd., Balto., Md 21218	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Metastatic Squamous cell carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. right upper lobe pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). right upper lobe pneumonia			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. E. Mahaffey M.D.		23B. DATE SIGNED 11/30/71	
23C. PHYSICIAN'S NAME (Type) J. E. Mahaffey		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/71	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Highway A.A.Ct.Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Krause Funeral Home 1216 S. Charles St.		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 11203		71 11203	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Effie Stokes				2. DATE AND HOUR OF DEATH 12-1-71 9⁴⁵ P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Md. B. COUNTY 807			
FULL NAME OF HOSPITAL OR INSTITUTION DO		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1411 N. Broadway		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-17-05	
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Trent Stanton				14. MOTHER'S MAIDEN NAME Cerawata Fleming			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Stanley Stokes-1411 N. Broadway			
18. 517X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY INSUFFICIENCY				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY FIBROSIS			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-11 19 70 to 12-1 19 71 that (I) (we) last saw the deceased alive on 10-14 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jerome Gaber				23B. DATE SIGNED 12-2-71		23C. PHYSICIAN'S NAME (Type) JEROME GABER	
23D. ADDRESS 5706 BELLONA AV		23E. DEGREE DEGREE		23F. DEGREE DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. FUNERAL DIRECTOR Ellis H. Jones-11297 Cuthbert			

1903

1903

THE CHAIR OF CALVIN



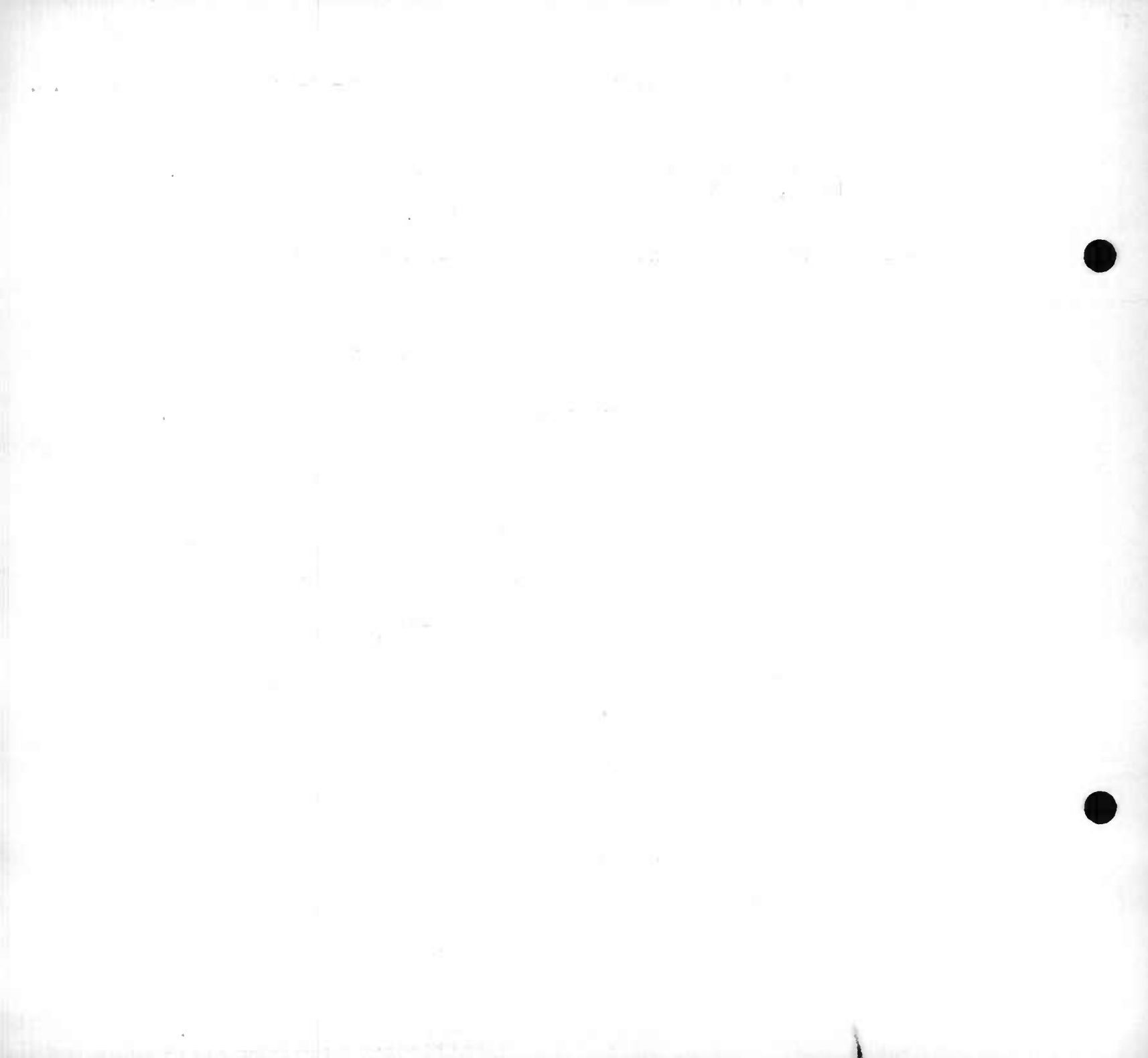
THE CHAIR OF CALVIN

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-column document, possibly a historical record or a book. The text is mirrored across the page, suggesting it might be a scan of a double-sided page or a very thin document.]

[Faint text lines are visible across the page, but they cannot be transcribed accurately.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11204	
BIRTH NO. 71 11204		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) EMMA HOLLENFEGER		2. DATE AND HOUR OF DEATH 12-01-71 9:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE, MD 21205		B. COUNTY 704	
5. SEX FEMALE		6. RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-13-93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 78	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Andrew Schach		14. MOTHER'S MAIDEN NAME Katherina ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-32-3965	
17. INFORMANT Mrs Lisette Kusser		ADDRESS 819 N. Broadway	
18. 431.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Arrest	
		(B) DUE TO, OR AS A CONSEQUENCE OF: INTRACEREBRAL Hemorrhage	
		(C) Spontaneous intra-cerebral hemorrhage	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ATHEROSCLEROSIS			
19A. DATE OF OPERATION 11/26		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRACEREBRAL Hemorrhage	
20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12/1 1971		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from 11/25 19 71 to 12/1 19 71 that (I) (we) last saw the deceased alive on 12/1 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David S. Zec		23B. DATE SIGNED 12/1	
23C. PHYSICIAN'S NAME (Type) DAVID S. ZEC		23D. ADDRESS Thomas Harris Hoson	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12/3/71	
24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR Henry Sander & Sons Inc.		ADDRESS Baltimore, Maryland 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

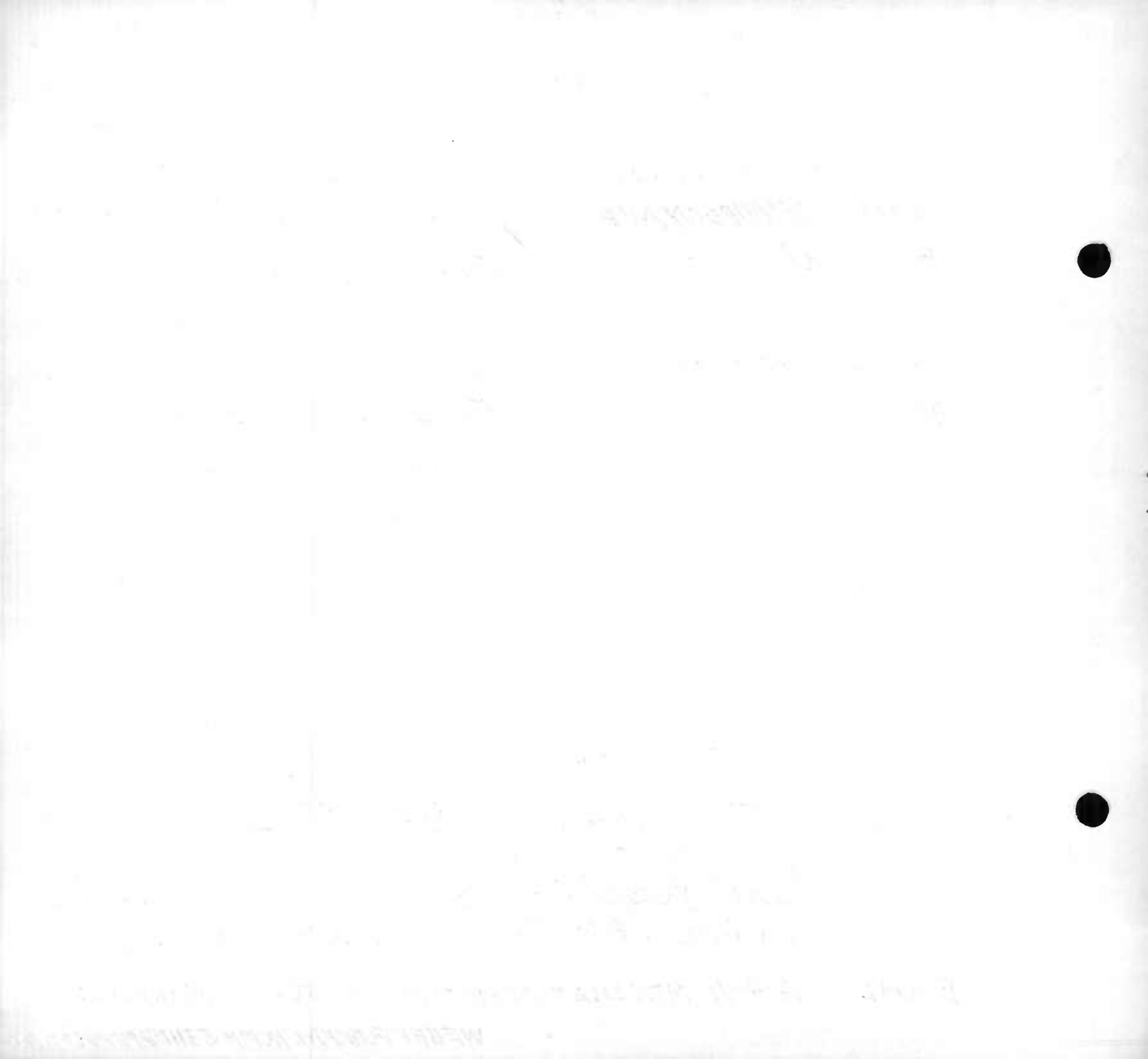
BIRTH NO. 71 11205		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11205	
1. NAME OF DECEASED (Type or Print) <i>Robertson, Mattie</i>		2. DATE AND HOUR OF DEATH <i>12/2/71 3:00 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> 1940 Eastern Avenue Baltimore, Maryland 21224		A. STATE <i>Maryland</i>		B. COUNTY <i>2002</i>	
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>2109 W. Fayette Street</i>		<i>21223</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/4/10</i>	9. AGE (in years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Katie</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224	
18. <i>734.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Glomerulonephritis 10 yrs.</i> (B) <i>Lupus Erythematosus</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (he) attended the deceased from <i>11/16</i> 19 <i>71</i> to <i>12/2</i> 19 <i>71</i> that (I) (she) last saw the deceased alive on <i>12/2</i> 19 <i>71</i> and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Roland C. Einhorn, M.D.</i>		23B. DATE SIGNED <i>12/2/71</i>		23C. PHYSICIAN'S NAME (Type) Roland C. Einhorn, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12/2/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arden Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 3 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Smith, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Althea Long, Curran</i>		25D. ADDRESS <i>2305 W. 7th</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11206	
BIRTH NO. 71 11206		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SARAH W. MORGAN		2. DATE AND HOUR OF DEATH 12/2/71 4:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION HOOD CONV. HOME		A. STATE MARYLAND		B. COUNTY BALTO	
5313 EDMONDSON AVE		C. CITY OR TOWN CRODSONVILLE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH JUN 16 1908		9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME THOMAS MORGAN		14. MOTHER'S MAIDEN NAME SARAH TARELTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT FLORENCE WILKINS MELROSE AVE	
18. 412.4 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/22 to 12/2 19 71 , that (I) (we) last saw the deceased alive on 11/22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Earl Case				23B. DATE SIGNED 12/2/71	
23C. PHYSICIAN'S NAME (Type) J. EARL PASS, M.D.				23D. ADDRESS 4001 WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-4-71		24C. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	
24D. LOCATION BALTO. MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 23 1971		25B. NAME OF REGISTRAR Robert E. Galley, M.D.	
25C. FUNERAL DIRECTOR WEBER FUNERAL HOME		25D. ADDRESS 5313 EDMONDSON AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 11207

BIRTH NO. 71 11207

1. NAME OF DECEASED
(Type or Print)

Theodore Wm Brown

2. DATE AND HOUR OF DEATH

11/30/71 7:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIV of MARYLAND Hosp

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

501 Dolphin ST 21217

5. SEX

M

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

1/22/09

9. AGE (in years last birthday)

62

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

Farming

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William H. Brown

14. MOTHER'S MAIDEN NAME

Jane Ann Diggs

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-22-0120

17. INFORMANT

Arabella Brown (sister)

ADDRESS

same

18. 0389113209

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

GRAM Negative septicemia, SHOCK, Meningitis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

NO

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/29 1971 to 11/30 1971 that (I) (we) last saw the deceased alive on 11/30 1971 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jerome Koepfel M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/30/71

23C. PHYSICIAN'S NAME (Type)

Jerome Koepfel M.D.

23D. ADDRESS

UNIV of MD Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Dec. 4, 1971

24C. NAME OF CEMETERY or CREMATORY

Piney Grove Cem.

24D. LOCATION

Boring, Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 3 1971

25B. NAME OF REGISTRAR

Robert E. Fahn, M.D.

25C. FUNERAL DIRECTOR

H. J. Schaubert Caring Mills, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11208
BIRTH NO.		71 11208		
1. NAME OF DECEASED (Type or Print) Charlotte V. Hall		2. DATE AND HOUR OF DEATH Nov 30, 1971 9:12 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital		A. STATE Maryland B. COUNTY Balto. C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2107 Hargrove Street 1204		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/197	9. AGE in years (last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Solomon Montague		14. MOTHER'S MAIDEN NAME Emma Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Esther Jones 3424 St Ambrose Ave.
18. 421.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Renal Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Mycotic Aneurysm DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 month
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Resection Mycotic Aneurysm 25 days		
19A. DATE OF OPERATION 11/15/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mycotic Aneurysm		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 10/28 1971 to 11/30 1971 that (I) (we) last saw the deceased alive on NOV 30 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Laurence Blumhage M.D.		23B. DATE SIGNED 11/30/71		23C. PHYSICIAN'S NAME (Type) Laurence Blumhage
23D. ADDRESS 928 E. North Ave.		23E. FUNERAL DIRECTOR Wm C March		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery
24D. LOCATION Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. ADDRESS 928 E. North Ave.		

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BALTIMORE CITY HEALTH DEPARTMENT

71 11209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11209

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Winfrey (Winifred) H. White Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 12 1 71		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year 12 1 71		Hour 8:05 p.m.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1204		6. SEX male 7. RACE Negro 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. DATE OF BIRTH 11-29-18		10. AGE (In years last birthday) 53		E. STREET AND NUMBER 322 E. 21st Street
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Winfrey H. White Sr
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY Printing Co		15. MOTHER'S MAIDEN NAME Estella Lee
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Cora White 322 E 21st Street
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/2/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71		24C. NAME OF CEMETERY or CREMATORY St Luke Cemetery
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.
24D. LOCATION (City, town, or county) (State) Reisterstown, Md.				

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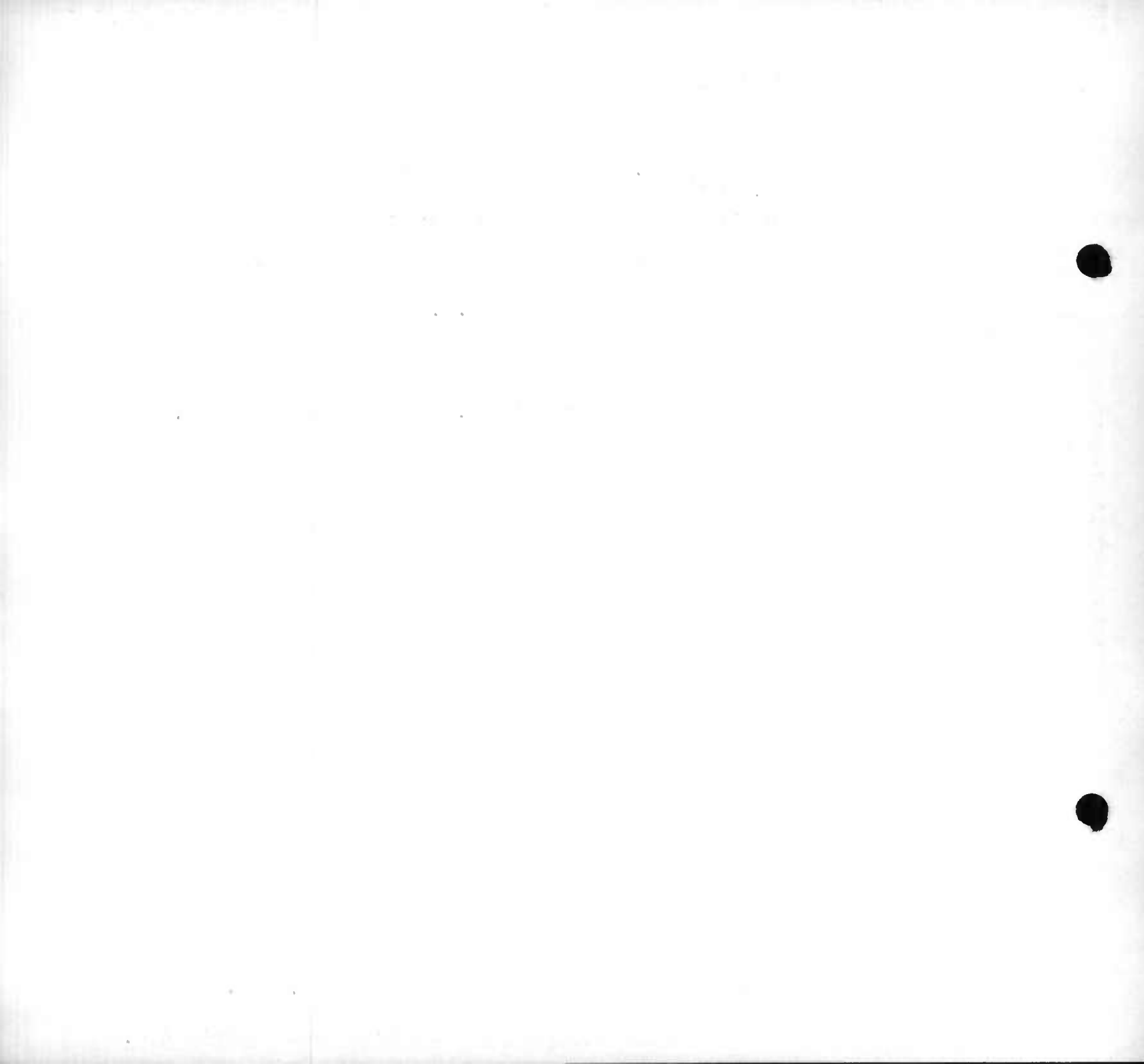
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B2601		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11210	
BIRTH NO. 71 11210		CERTIFICATE OF DEATH		71 11210	
1. NAME OF DECEASED (Type or Print) Minnie BAKER			2. DATE AND HOUR OF DEATH 11/30/71 10:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 502 W. Lafayette St		
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/83	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) N.C.		
13. FATHER'S NAME Faith Hellums			14. MOTHER'S MAIDEN NAME Vinnie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 243-60-6448		
17. INFORMANT Mr. Julius Knotts			ADDRESS 502 W. Lafayette Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Anoxia (B) S.C.V. Disease DUE TO, OR AS A CONSEQUENCE OF: (C) ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 8/2/68 to 11/30/71 that (I) (we) last saw the deceased alive on 11/12/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
23A. SIGNATURE Joseph S. Blum			23B. DATE SIGNED 11/30/71		
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD			23D. ADDRESS 1115 N CALVERT ST		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12-3-71		
24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery			24D. LOCATION (City, town, or county) (State) Balto., Md.		
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		
25C. FUNERAL DIRECTOR Wm C March			ADDRESS 928 E North Ave.		



FOR APPROVAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 11211				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11211	
1. NAME OF DECEASED (Type or Print) HOBACK, HARRY NMI				2. DATE AND HOUR OF DEATH 12/2/71					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA 5200 C. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 102 S. Broadview Boulevard					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/89	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10B. KIND OF BUSINESS OR INDUSTRY Plumbing			11. BIRTHPLACE (State or foreign country) Wise, Virginia			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Mitchell B. Hoback			14. MOTHER'S MAIDEN NAME Agnes Kilbourn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/5/17 - 8/26/19			16. SOCIAL SECURITY NO. 18 54 21A			17. INFORMANT VA Hospital Records			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). fractured right hip			19. DATE OF OPERATION 11/30/71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED A-K amputation rt. leg for gangrene			
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-23-71 ?			
21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 102 S. Broadview Blvd 5200			
21D. TIME OF INJURY (APPROX.) 10-23-71 ?			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? Fall -			
22. I certify that (this hospital) attended the deceased from October 24th 19 71 to December 2 19 71 , that (I/we) last saw the deceased alive on December 2nd 19 71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did/did not) view the body after death.									
23A. SIGNATURE Penney C. Gertsen MD						23B. DATE SIGNED 12/2/71			
23C. PHYSICIAN'S NAME (Type) PENNEY C. GERTSEN MD						23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12/4/71			24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery			
24D. LOCATION (City, town, or county) (State) Dorsey Howard Maryland			25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971			25B. NAME OF REGISTRAR Raymond E. Fink, R.D.			
25C. FUNERAL DIRECTOR ADDRESS Raymond C. Fink Glen Burnie, Md.									

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11212	
BIRTH NO. 71 11212		1. NAME OF DECEASED (Type or Print) AMANDA BARNES		2. DATE AND HOUR OF DEATH 11-28-71 2:15 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY ST. MARY'S 6800		
			C. CITY OR TOWN SCOTLAND		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-27-93	9. AGE (In years lost birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME MAJOR BARNES		14. MOTHER'S MAIDEN NAME SOPHIE RUSSELL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 16 4847B		17. INFORMANT MRS. BEULAH BUTLER - SCOTLAND, MD.	
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Embolism			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 23 1971 to Nov 28 1971 that (I) (we) last saw the deceased alive on Nov 28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE N. B. ROSENHEIM M.D.				23B. DATE SIGNED 28 Nov 71	
23C. PHYSICIAN'S NAME (Type) N. B. ROSENHEIM M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/4/1971		24C. NAME OF CEMETERY or CREMATORY ST. LUKES CEMETERY	
24D. LOCATION SCOTLAND, MD.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR John M. Welch	
		ADDRESS LEONARDTOWN, MD.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. **71 11213**

BIRTH NO. **71 11213**

1. NAME OF DECEASED (Type or Print) <i>Arus C. Stewart</i>		2. DATE AND HOUR OF DEATH <i>Dec. 1, 1971</i> <i>9:30 A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>6115 O'Donnell St.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2636</i>	
5. SEX <i>M</i> 6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11-5-1882</i>		9. AGE (In years last birthday) <i>89</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Caretaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cemetery</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs. Margant Berkey</i>		ADDRESS <i>6130 O'Donnell St.</i>	
18. <i>412.4</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arterio sclerotic CV. Disease</i> (B) <i>AGING</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>?</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1946</i> 19 to <i>12-1</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>11-30</i> 19 <i>71</i> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Jason H. Gaskel M.D.</i>		23B. DATE SIGNED <i>12-2-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Jason H. Gaskel M.D.</i>		23D. ADDRESS <i>6315 Conkling St. Baltimore Md 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-4-71</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Schwartz's Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 3 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Faber, R.D.</i>	
25C. FUNERAL DIRECTOR <i>Thelma A. Hoffmann</i>		ADDRESS <i>3218 Hudson St.</i>	

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The Bureau of Land

San Francisco

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San Francisco County

1877

San Francisco

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San Francisco

71 11214

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11214

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) OSCAR HELBING		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year		3. DATE PRONOUNCED DEAD Month Day Year December 1, 1971		Hour 7:11 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 804			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 26 APR 1895		10. AGE (In years last birthday) 76 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2135 E. Federal Street			
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME OSCAR HELBING, JR.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		14B. KIND OF BUSINESS OR INDUSTRY SHED BUILDING		15. MOTHER'S MAIDEN NAME JULIA			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 218-18-2042		18. INFORMANT MARIE VESELY, 2135 E. FEDERAL ST. 21213		ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED: 12/1/71 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4 DEC 71		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO, MD. 21213	
25A. DATE REC'D BY HEALTH DEPT. DEC 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Udovich Funeral Home, BALTO, MD. 21206		ADDRESS	

1881-1882



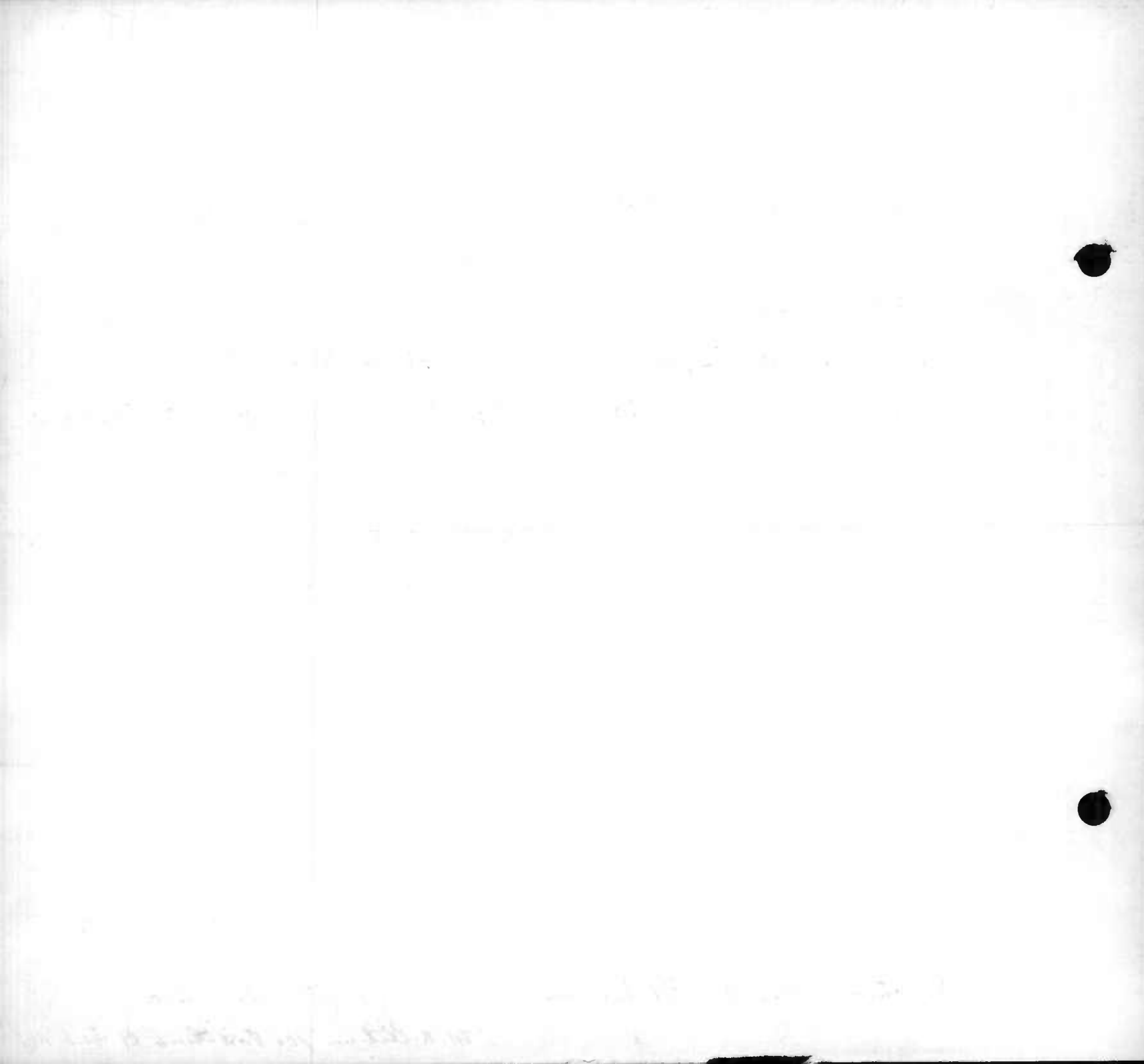
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1881-1882

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

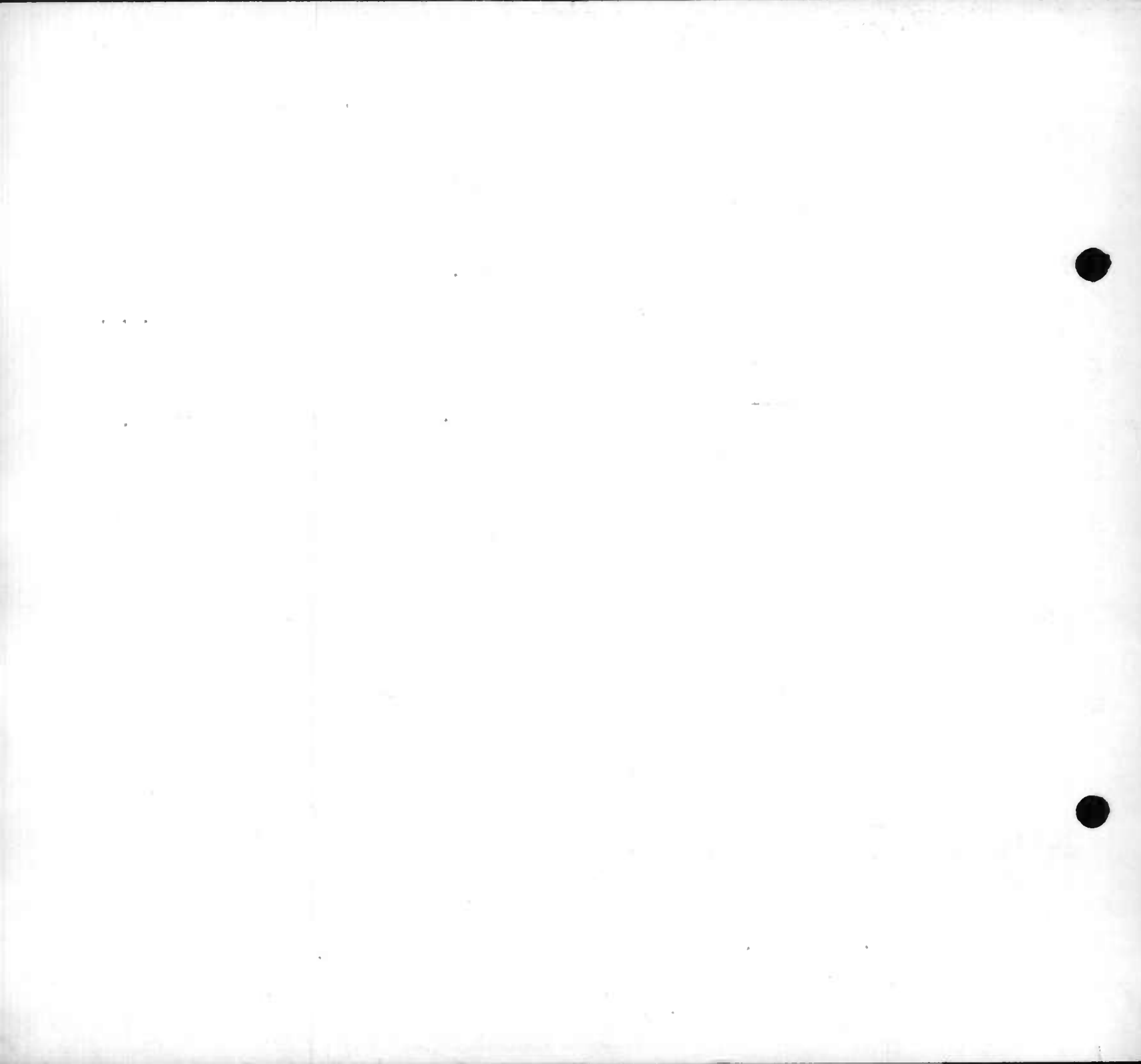
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11215	
BIRTH NO. 71 11215					
1. NAME OF DECEASED (Type or Print) CAVELL ALBERT		2. DATE AND HOUR OF DEATH 11/25/71 8:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MD KEN HOSP		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1401			
5. SEX M 6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/14/11 9. AGE (in years last birthday) 60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALEMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME William M. Cavell		14. MOTHER'S MAIDEN NAME ANNA MAE BALL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09 8398		17. INFORMANT MRS DOROTHY SHAFF, RT#4 FRED MD	
18. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coma et al		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic alcoholic (C) hepatomegaly			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/22 19 71 to 11/25 19 71 that (I) (we) last saw the deceased alive on 11/25 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Garasso MD		23B. DATE SIGNED 11/26/71		23C. PHYSICIAN'S NAME (Type) MICHAEL GARASSO MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11/26/71		24C. NAME OF CEMETERY or CREMATORY H. Lincoln	
25A. DATE REC'D BY HEALTH DEPT. D-C 3 1971		25B. NAME OF REGISTRAR Robert E. Faber MD		25C. FUNERAL DIRECTOR W. R. ... 106 East ...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11216	
BIRTH NO. R-400 71 11216				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mary (Di Nardo) Reale			2. DATE AND HOUR OF DEATH Dec. 2, 1971 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4408 Findley Road			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2642		
5. SEX F			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY None		8. DATE OF BIRTH Nov. 8, 1881
11. BIRTHPLACE (State or foreign country) Italy			9. AGE (In years last birthday) 90		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Antonio Antevai		
14. MOTHER'S MAIDEN NAME Carmela			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Mr. Peter Monaco 4408 Findley Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinomatosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cardiac Decompensation			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Adenocarcinoma - Right Breast 5 years		
19A. DATE OF OPERATION 01/965			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast Cancer		
20A. AUTOPSY (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 1970 to November 30, 1971 that (I) (we) last saw the deceased alive on November 30, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin F. Polek			23B. DATE SIGNED December 4, 1971		
23C. PHYSICIAN'S NAME (Type) Dr. Melvin F. Polek			23D. ADDRESS 3603 Belair Rd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/71		24C. NAME of CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Thomas M. Dally, 322 N. Highland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-553 71 11217</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 11217</u>	
1. NAME OF DECEASED (Type or Print) <u>HAMMOND, HENRY (NMI)</u>				2. DATE AND HOUR OF DEATH <u>December 2, 1971</u> <u>6:45 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>Negroid</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>9-20-96</u>		9. AGE (In years last birthday) <u>75</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Abe Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Ann Sellis</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>9-21-18 to 8-6-19</u>				16. SOCIAL SECURITY NO. <u>220-09-3991</u>		17. INFORMANT <u>Records V. A. Hospital</u> ADDRESS <u>3900 Loch Raven Blvd., Baltimore, Md. 21218</u>	
18. <u>412.41-003.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CHF WITH SHOCK</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARRHYTHMIA, WITH ASCVD</u>				CAUSE OF DEATH AND (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ARRHYTHMIA, WITH ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SALMONELLOSIS WITH BACTEREMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>July 14,</u> <u>19 71</u> to <u>December 2,</u> <u>19 71</u> , that <u>XX</u> (we) last saw the deceased alive on <u>December 2,</u> <u>19 71</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Kameel Farag</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>KAMEEL FARAG, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12/8/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT Auburn Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> ADDRESS <u>1206 W North Ave</u>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11218

BIRTH NO.

1. NAME OF DECEASED (Type or Print) David O. Howard		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> December 4, 1971		Hour 7:00 P M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 700 Brune Street		3. DATE PRONOUNCED DEAD December 4, 1971		Hour 7:30 P M.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 68	11. BIRTHPLACE (State or foreign country) Calvert County Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Peter Cornelius Howard		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
15. MOTHER'S MAIDEN NAME Martha Johnson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 214-01-5538
18. INFORMANT Mrs Berneice Barnes, 700 Brune St		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 5, 1971				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/71		24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery
24D. LOCATION (City, town, or county) Baltimore, Md		24E. LOCATION (State) Md		
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave

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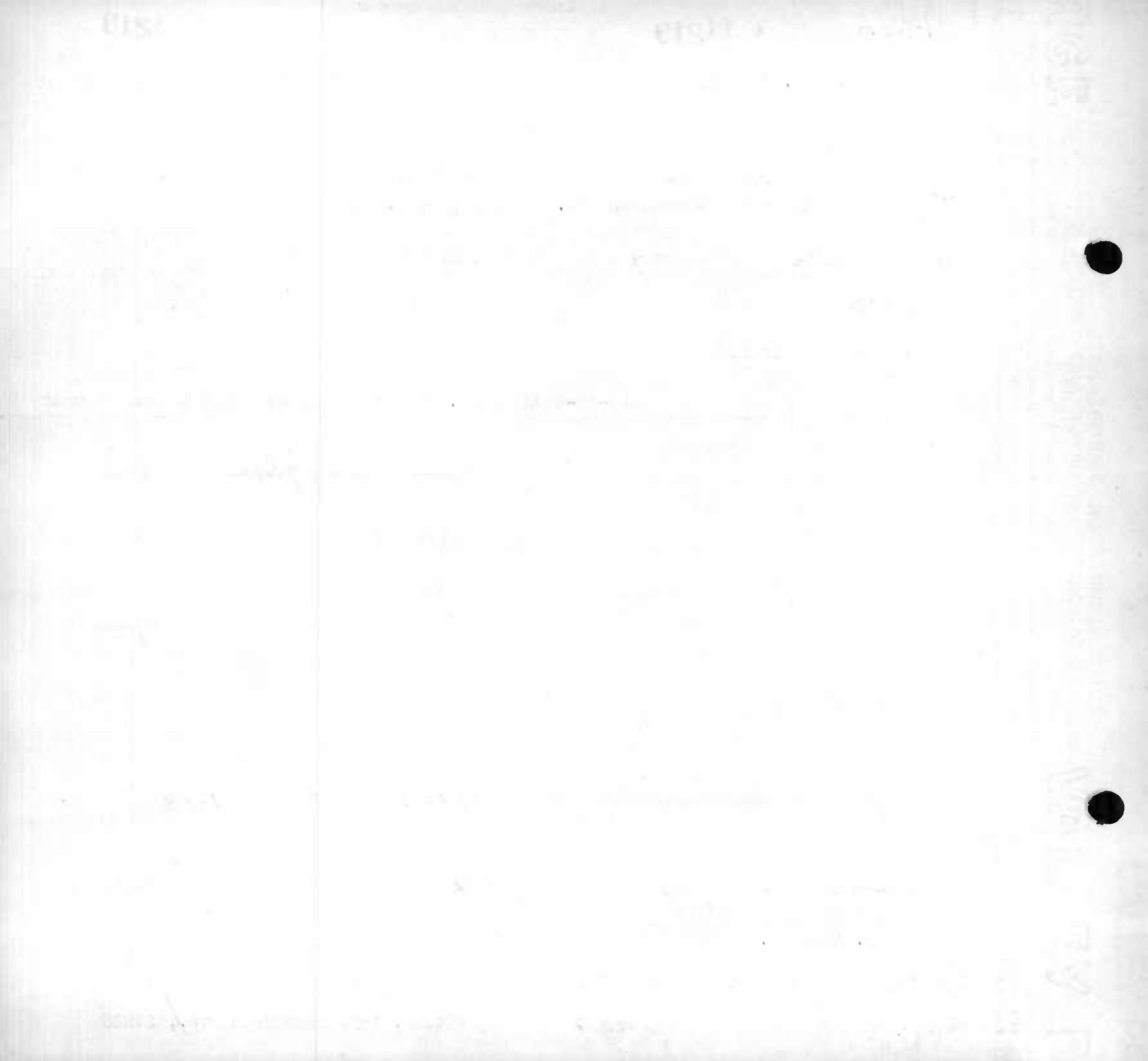
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11219	
M-266 71 11219 BIRTH NO.				12/3/71 DATE AND HOUR OF DEATH		10 P. M. TIME	
1. NAME OF DECEASED (Type or Print) Oma J. McCrory				2. DATE AND HOUR OF DEATH 12/3/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Hood Nursing Home North Bend & Edmondson Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore 5300 C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 442 Greenlow Road			
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1879	9. AGE (In years lost birthday) 91	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ----- Boward				14. MOTHER'S MAIDEN NAME -----			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-48-8698		17. INFORMANT ADDRESS Mrs. Ellsworth Carter, 8846 C Town & Country Blvd			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/24 I Cardio-Pulmonary failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCD. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CBS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks Year Years			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11/12/71 to 12/3/71 that (I) (we) last saw the deceased alive on 11/23/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 				23B. DATE SIGNED 12/4/1971		23C. PHYSICIAN'S NAME (Type) Dr. Adnan M. Sonmez	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/71		24C. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		24D. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Ave., 21228		VS 150-REV. 1/1/68	



BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 11220					
BIRTH NO.													
1. NAME OF DECEASED (Type or Print) Jack Hyner						2. DATE OF DEATH Known <input type="checkbox"/> Found: <input checked="" type="checkbox"/> Month: 11 Day: 30 Year: 71 Hour: 9:00 A.M.							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1300 block Frankchilds						3. DATE PRONOUNCED DEAD Month: 11 Day: 30 Year: 71 Hour: 9:00 A.M.							
5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE: Md B. COUNTY: 201													
6. SEX Male		7. RACE Negro		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
9. DATE OF BIRTH 3/6/23		10. AGE (In years lost birthday) 48		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2001 E Baltimore St							
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Tansy Hyner							
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME ???							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes WW2				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr Robert Liggon, 3518 Garrison Ave							
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).													
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes													
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. DATE SIGNED: 11-30-71 EXAMINER'S NAME (Type) Werner U. Spitz, M.D.													
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/8/71		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				25C. FUNERAL DIRECTOR ADDRESS A.olphus Halstead 1206 W North Ave					

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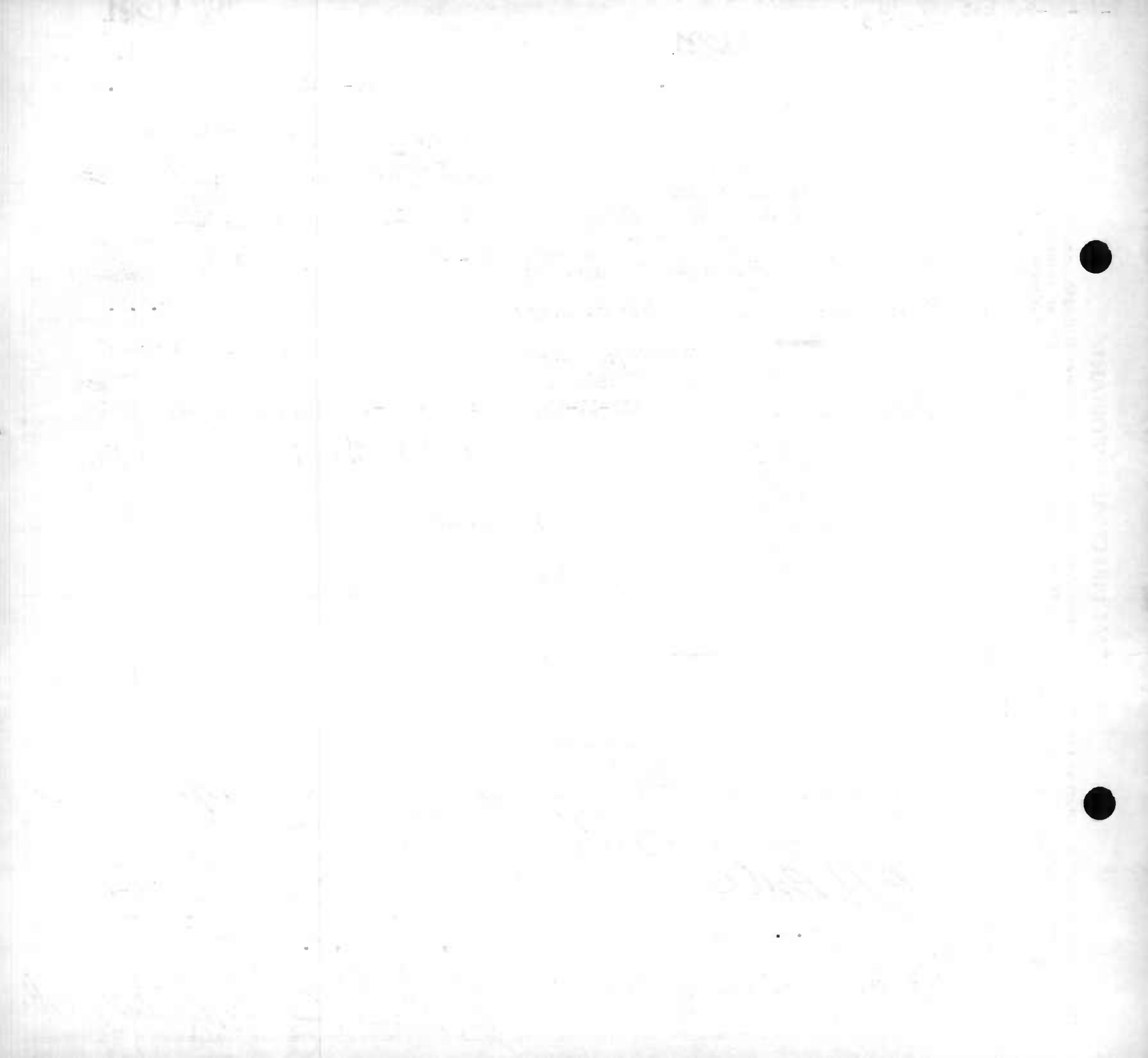
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

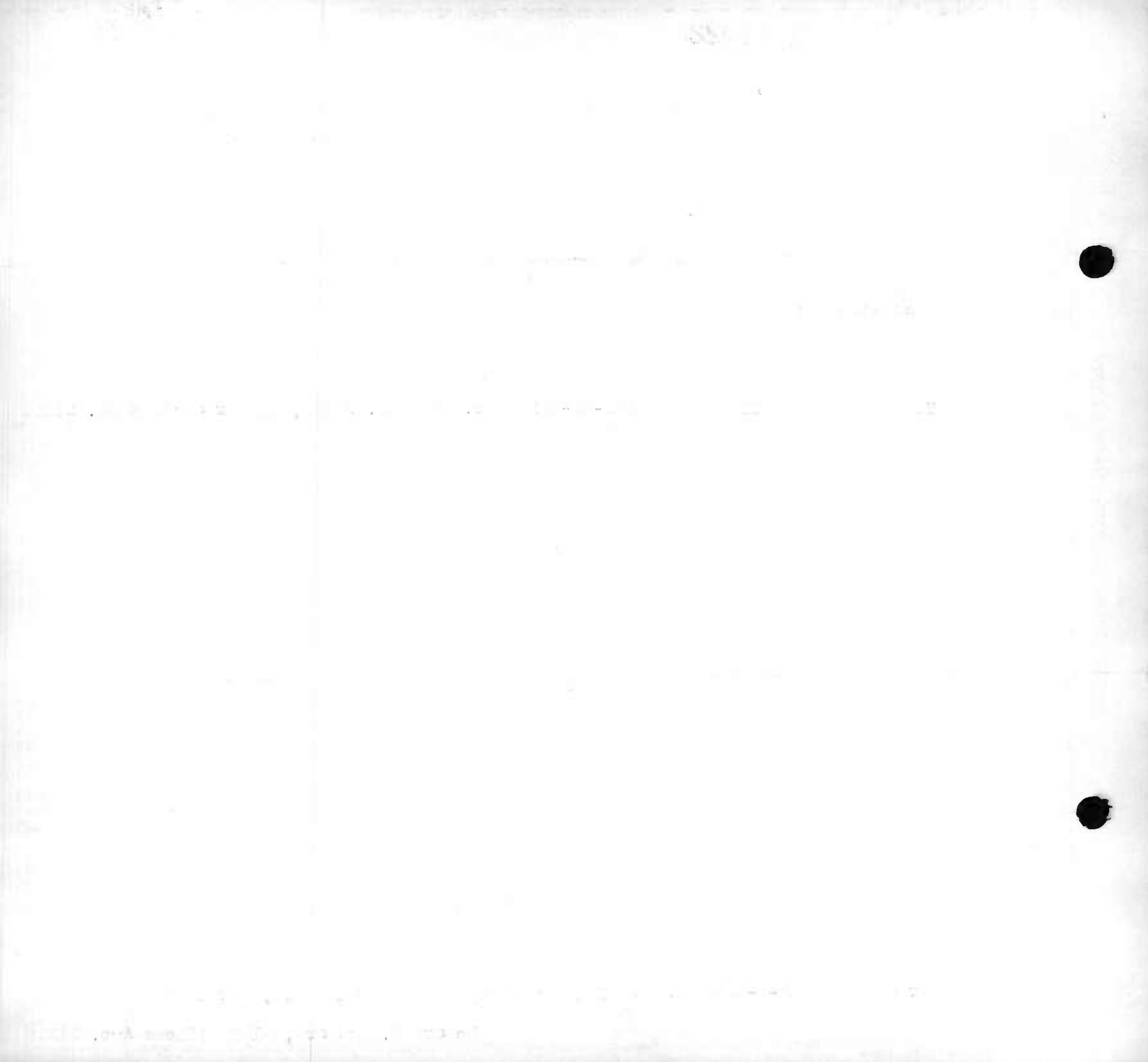
BIRTH NO. <u>H-155</u>		71 11221		CERTIFICATE OF DEATH		REG. NO. <u>71 11221</u>	
1. NAME OF DECEASED (Type or Print) <u>Herbert H. Hoffman</u>				2. DATE AND HOUR OF DEATH <u>12-1-1971</u> <u>9.35</u> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> <u>2636</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE CITY</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>6500 Colgate Avenue</u> <u>21222</u>							
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-7-1908</u>	9. AGE (In years last birthday) <u>63</u>	10. If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1ST. HELPER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL MGR.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Hubbard HOFFMAN</u>				14. MOTHER'S MAIDEN NAME <u>Flossie CLARKE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-07-2244</u>		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>12/1</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Central Thrombosis</u> 20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>ASCVD</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Coronary</u> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/1</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>1 day</u> <u>?</u>							
22. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> 19 <u>71</u> to <u>12/1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R.H. Brooks</u>				23B. DATE SIGNED <u>12-1-71</u>		23C. PHYSICIAN'S NAME (Type) <u>R.H. Brooks</u>	
23D. ADDRESS <u>Baltimore City Hospitals-4940 Eastern Avenue, Baltimore, Md. 21224</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/1/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1971</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>R. E. Taylor</u>		25D. ADDRESS <u>R. E. Taylor</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11222	
J-520 71 11222		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JANES, CHARLES RAYMOND.		2. DATE AND HOUR OF DEATH 12-2-71 5.10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY 2641			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4411 ANNTANA AVE - BALTO - MD 21206					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-27-21	9. AGE (In years last birthday) 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME CHARLES JANES		14. MOTHER'S MAIDEN NAME ELLA HANSEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		16. SOCIAL SECURITY NO. 212-12-0623		17. INFORMANT ADDRESS Mr. David R. Janes, 310 Bryanstone Rd. 21136	
18. 43601Y-230.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CEREBRAL VASCULAR ACCIDENT (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTENSION + DIABETES		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL VASCULAR ACCIDENT (B) HYPERTENSION + DIABETES DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-1 19 71 to 12-2 19 71 that (I) (we) last saw the deceased alive on 12-2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julio A. DeTo M.D.				23B. DATE SIGNED 12-2-71	
23C. PHYSICIAN'S NAME (Type) JULIO A. DETO M.D.				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-1971		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

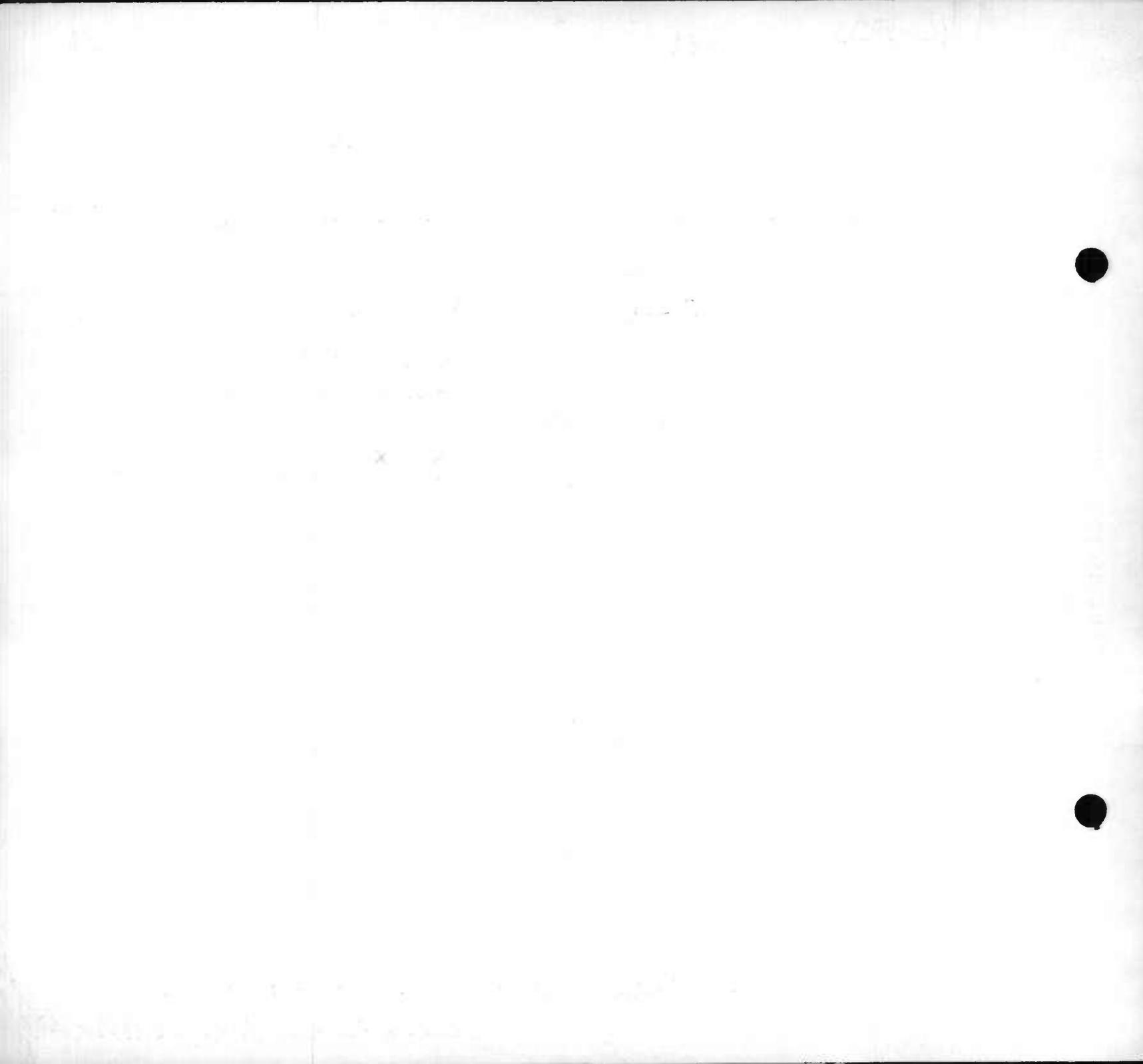
BIRTH NO. 1-550		71 11223		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11223	
1. NAME OF DECEASED (Type or Print) Mary E. Dammann				2. DATE AND HOUR OF DEATH 12/2/71 8:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 43 So. Balto. Gen. Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY 2102			
FULL NAME OF HOSPITAL OR INSTITUTION 43 So. Balto. Gen. Hosp.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 1132 Carroll St.			
5. SEX M.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1878	9. AGE (In years lost birthday) 93	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY at Home			11. BIRTHPLACE (State or foreign country) Elkridge Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Allen Watts				
14. MOTHER'S MAIDEN NAME Mary Pierce			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				
16. SOCIAL SECURITY NO. -			17. INFORMANT Miss Lillian Dammann				
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ARTERIO SCLEROTIC			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC BRONCHITIS			DUE TO, OR AS A CONSEQUENCE OF: 8 yrs.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 2nd 1968 to Dec. 2nd 1971 and that (I) (we) last saw the deceased alive on Dec 3rd 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harry F. Kates M.D.				23B. DATE SIGNED Dec. 3rd. 1971		23C. PHYSICIAN'S NAME (Type) HARRY F. KATES M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/71		24C. NAME OF CEMETERY or CREMATORY London Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR John E. Taylor M.D.		25C. FUNERAL DIRECTOR John J. Cowan & Son Inc.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

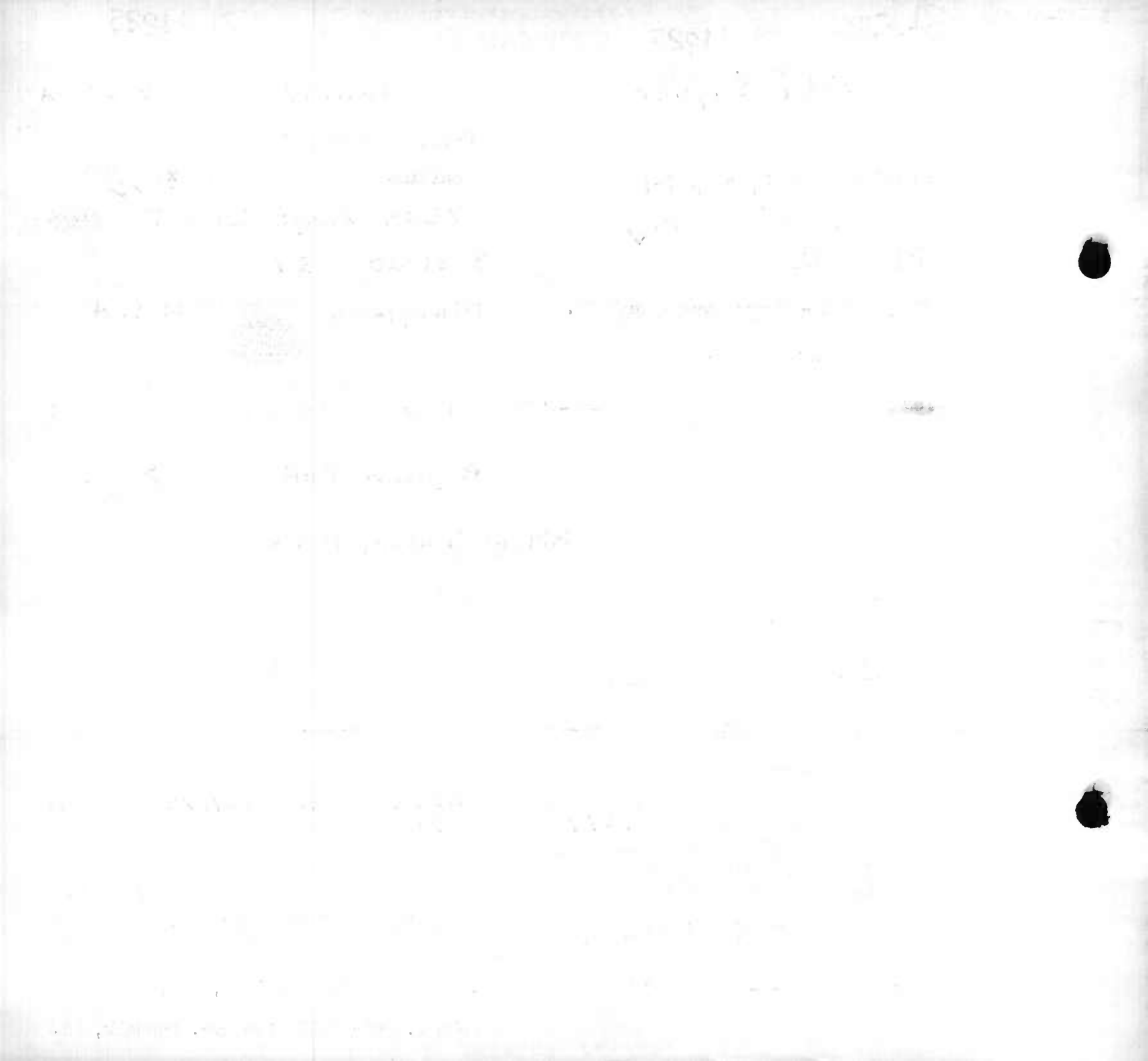
<div style="display: flex; justify-content: space-between;"> W-300 71 11224 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 71 11224	
1. NAME OF DECEASED (Type or Print) ROY H WHITE		2. DATE AND HOUR OF DEATH 12/1/71 1045pm M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY OF MD HOSPITAL		A. STATE MD B. COUNTY BALTIMORE	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 22 S GREENE ST 6711 CLEVELAND AVE	
5. SEX ♂	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY STEEL	9. AGE (In years last birthday) 84
13. FATHER'S NAME ANDREW WHITE		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME UNOBTAINABLE	
16. SOCIAL SECURITY NO. 26-10-5001		12. CITIZEN OF WHAT COUNTRY USA	
17. INFORMANT MRS. HELEN JEPHERD		ADDRESS DAUGHTER 1011 CLEVELAND AVE. BALTO 21222	
18. 208X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH CAUSE XIA (A) IMMEDIATE CAUSE POLYCYTEMIA - VERA DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) POLYCYTEMIA - VERA DUE TO, OR AS A CONSEQUENCE OF:	
		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		SUB DURAL HEMATOMA ?	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ricardo A. Condon		23B. DATE SIGNED 12/1/71	
23C. PHYSICIAN'S NAME (Type) RICARDO A CONDON MD		23D. ADDRESS UNIV OF MD HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 6 DEC 71	24C. NAME OF CEMETERY OR CREMATORY Morton Ridge Memorial Park	24D. LOCATION (City, town, or county) (State) HOWARD CO., MD.
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971	25B. NAME OF REGISTRAR Robert E. ...	25C. FUNERAL DIRECTOR CLERICH FUNERAL HOME, DUNDALK, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

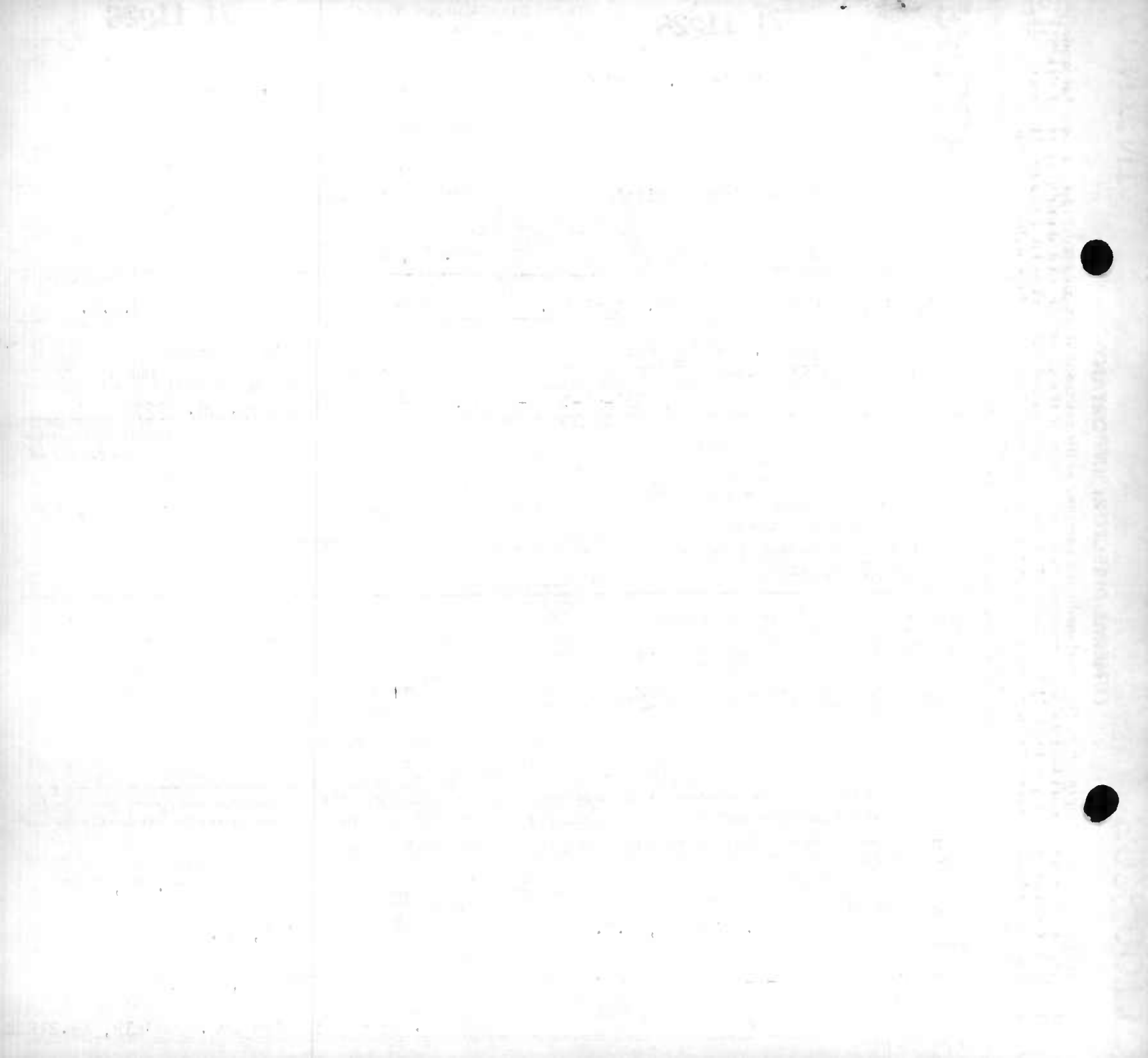
S-536		71 11225		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11225	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) John M. Snyder			
2. DATE AND HOUR OF DEATH 12/11/71 14:20 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. BALTO. B. COUNTY 5300			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 7504 Lange Street 21224							
5. SEX Male		6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-31-20	
						9. AGE (In years last birthday) 51	
						If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Helper - Crown Cork & Seal Co.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A.				13. FATHER'S NAME David Snyder			
14. MOTHER'S MAIDEN NAME Harriet				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II			
16. SOCIAL SECURITY NO. 220-07-6757				17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224			
18. 394.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Progressive CHF DUE TO, OR AS A CONSEQUENCE OF: (B) Mitral Incompetence DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 5 yrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner if <input checked="" type="checkbox"/>)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/26/71 to 12/11/71 1971 that (I) (we) last saw the deceased alive on 12/1/71 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lee R. Baker				23B. DATE SIGNED 12/1/71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) LEE R. BAKER				23D. ADDRESS 4940 Eastern Avenue Balto. City Hospital Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-71		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Gardens		24D. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

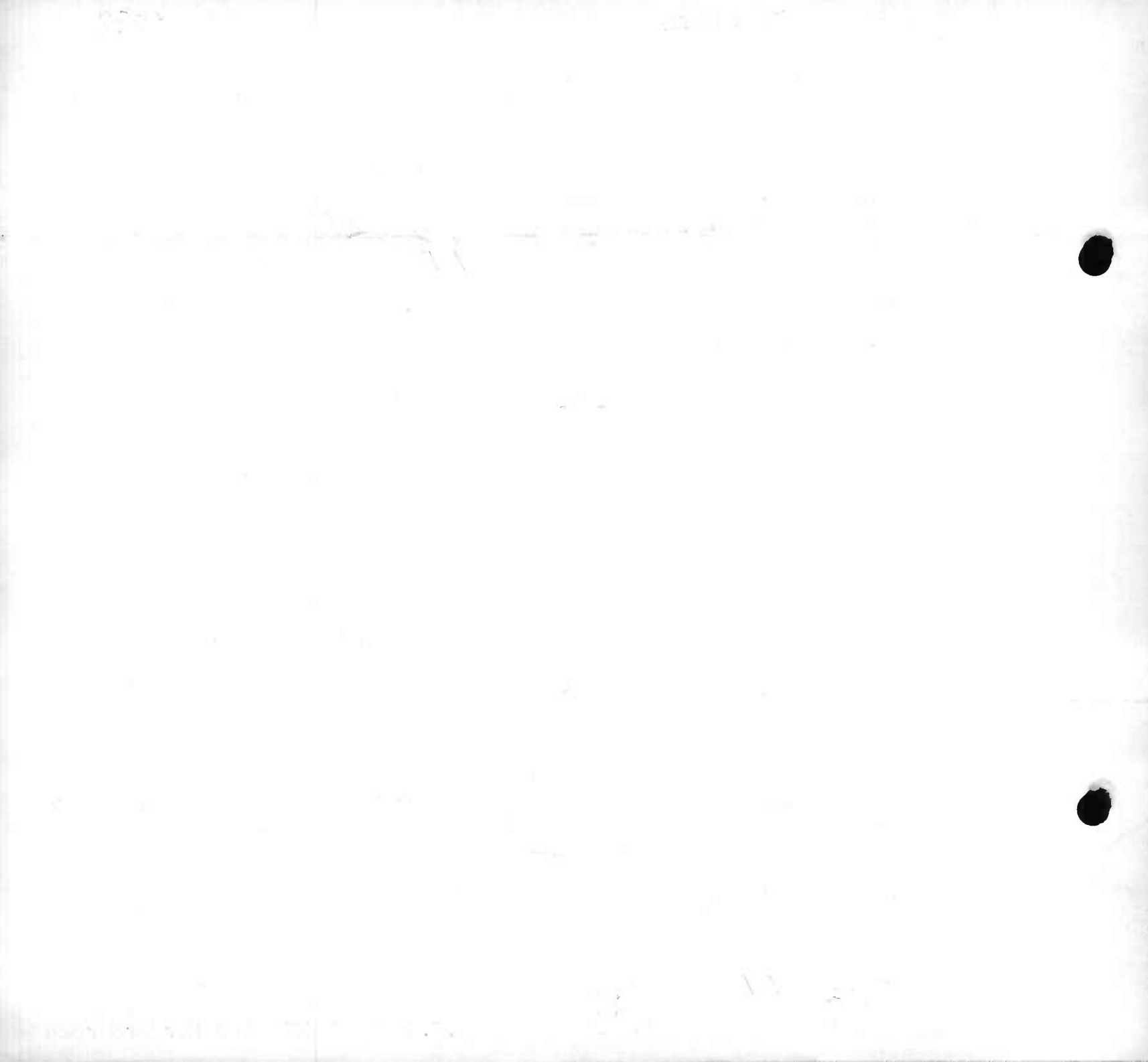
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11226	
P-362 71 11226 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">William E. Pedrick</div>		2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 1.2em;">November 29, 1971</div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 1.5em;">31</div> <div style="text-align: center; font-size: 1.2em;">Baltimore City Hospital</div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7609 Iroquois Road			
5. SEX <div style="display: flex; justify-content: space-between;"> Male White </div>		6. RACE <div style="display: flex; justify-content: space-between;"> White </div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <div style="font-size: 1.2em;">Sept. 30, 1906</div>		9. AGE (In years last birthday) <div style="font-size: 1.2em;">65</div>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">Tin Mill Foreman</div>	
10A. KIND OF BUSINESS OR INDUSTRY <div style="font-size: 1.2em;">Beth. Steel Co.</div>		11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em;">Maryland</div>		12. CITIZEN OF WHAT COUNTRY? <div style="font-size: 1.2em;">U.S.A.</div>	
13. FATHER'S NAME <div style="font-size: 1.2em;">John S. Pedrick</div>		14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em;">Annie Gephardt</div>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="font-size: 1.2em;">No</div>		16. SOCIAL SECURITY NO. <div style="font-size: 1.2em;">213-07-1928-A</div>		17. INFORMANT Wife: Mrs. Emma Pedrick ADDRESS 7609 Iroquois Road Balto. Md. 21219	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <div style="font-size: 1.2em;">Myocardial Infarction</div>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.2em;">? immed.</div>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="font-size: 1.2em;">Hypertensive CV Dis</div>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em;">10 yrs.</div>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em;">Obesity</div>			(C) DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em;">20 yrs.</div>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <div style="font-size: 1.2em;">O</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <div style="font-size: 1.2em;">No</div>		20A. AUTOPSY? (Yes or No) <div style="font-size: 1.2em;">No</div>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <div style="font-size: 1.2em;">No</div>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <div style="font-size: 1.2em;">No</div>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <div style="font-size: 1.2em;">No</div>	
21D. TIME OF INJURY (APPROX.) <div style="font-size: 1.2em;">No</div>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <div style="font-size: 1.2em;">No</div>	
22. I certify that (I) (this hospital) attended the deceased from July 1960 to 11-29-71 that (I) (we) last saw the deceased alive on 11-18-71 and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <div style="font-size: 1.5em;">Roger G. Windsor</div>				23B. DATE SIGNED <div style="font-size: 1.2em;">Nov. 30, 1971</div>	
23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em;">Roger G. Windsor, M.D.</div>				23D. ADDRESS <div style="font-size: 1.2em;">520 D Street Sparrows Point, Md. 21219</div>	
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em;">Burial</div>		24B. DATE <div style="font-size: 1.2em;">12-3-71</div>		24C. NAME OF CEMETERY OR CREMATORY <div style="font-size: 1.2em;">Oak Lawn Cemetery</div>	
24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em;">Baltimore, Maryland</div>		25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.5em;">DEC 6 1971</div>			
25B. NAME OF REGISTRAR <div style="font-size: 1.2em;">Robert E. Valley, Jr.</div>		25C. FUNERAL DIRECTOR ADDRESS <div style="font-size: 1.2em;">John J. Duda 7922 Wise Ave. Dundalk, Md. 21222</div>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11227
I-260 71 11227				
1. NAME OF DECEASED (Type or Print) HELEN RUBIN IZER		2. DATE AND HOUR OF DEATH 12/2/71 1:30 P		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould, Conv.		A. STATE Md. B. COUNTY 2634		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1058 Steiger way		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/89	9. AGE (In years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Gideon H Weitzel		
14. MOTHER'S MAIDEN NAME Mary E. Adams		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-14-4328		17. INFORMANT ADDRESS Family records		
18. 4/12-3 I CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteroselectic Heart Disease				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized Anteroselectic (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Pneumonia (C) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia Using Treat Affecting Chronic Heart Failure				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from 8/2/71 to 12/2/71 that (I) (we) last saw the deceased alive on 11/30/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Alfred B. Bradley		23B. DATE SIGNED 12/2/71		23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS		23E. NAME OF REGISTRAR		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/71		24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cem
24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS C.F. EVANS & SON 8802 Harford road		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-340 71 11228		BALTIMORE CITY HEALTH DEPARTMENT		71 11228	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		RATHELL MARY E		2. DATE AND HOUR OF DEATH 11.30.71 at 5.20 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY 2534	
Sout Baltimore General Hospital.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
43		E. STREET AND NUMBER 617 Arson Avenue		21225	
5. SEX F.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-09	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John MATTHIAS		14. MOTHER'S MAIDEN NAME ELLEN ?		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ****		17. INFORMANT Arthur Rathell (same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ? Massive Myocardial Infarction. (B) DUE TO, OR AS A CONSEQUENCE OF: Pre - infarction Angina. (C) Oligurea & Uraemia. Ch. anaemia.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 11-16-71 to 11-30-71 that (I) (we) last saw the deceased alive on 11-30-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11.30.71	
23C. PHYSICIAN'S NAME (Type) D. S. SAWHNEY		23D. ADDRESS 3001 South Hanover St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/71		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Hwy., A.A. Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR George J. Gonco, 4001 Ritchie Hwy., Baltimore, Md.			

BIRTH NO.		71 11229		BALTIMORE CITY HEALTH DEPARTMENT		71 11229	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) K. MARIE REIMERS				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL				3. DATE PRONOUNCED DEAD November 30, 1971		Month Day Year Hour 8:30 A.	
6. SEX Female				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4-20-1894				10. AGE (In years last birthday) 77		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME John Walper		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
15. MOTHER'S MAIDEN NAME Katherine Lang				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-44-5434	
18. INFORMANT Mrs. Ruth Banks				19. ADDRESS 1561 Lister Road 21227		20. CAUSE OF DEATH Carbon Monoxide Intoxication	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carbon Monoxide Intoxication				22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carbon Monoxide Intoxication		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic cardiovascular disease				25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic cardiovascular disease		26. MEDICAL CERTIFICATION	
27. DATE OF OPERATION 2				28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No) yes	
30. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Garage		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1561 Lister Road	
33. TIME OF INJURY (APPROX.) 11-30-71 A.M.				34. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		35. HOW DID INJURY OCCUR? Subject inhaled carbon monoxide	
36. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				37. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		38. DATE SIGNED 12/1/71	
39. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.				40. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		41. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
42. BURIAL CREMATION, REMOVAL (Specify) Burial				43. DATE 12-3-1971		44. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
45. LOCATION (City, town, or county) Baltimore, Maryland				46. NAME OF REGISTRAR Howard H. Hubbard		47. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229	
48. DATE REC'D BY HEALTH DEPT. DEC 6 1971				49. NAME OF REGISTRAR Ronald N. Kornblum, M.D.		50. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-613		71 11230		BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		REG. NO. 71 11230	
1. NAME OF DECEASED (Type or Print) GARRIE VIRGINIA KEABITZ				2. DATE AND HOUR OF DEATH Dec. 2, 1971 4:20 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital 3001 S. Harwood Baltimore, Maryland 21230				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2101 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 786 W. Cross St.					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-29-94	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months: 7	11. Under 24 Hrs. Days: 7	12. Under 24 Hrs. Hours: 7	13. Under 24 Hrs. Min: 7
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Harvey				14. MOTHER'S MAIDEN NAME Sarah Dean					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Miss Charlotte Keabitz		ADDRESS above	
18. 153.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Carcinoma of sigmoid DUE TO, OR AS A CONSEQUENCE OF: (B) with metastasis to the liver DUE TO, OR AS A CONSEQUENCE OF: (C) lung & bone (2) Pneumonia (3) Dehydration				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION no		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Dec. 2 19 71 to Dec. 2 19 71 that (I) (we) last saw the deceased alive on Dec. 2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. CAUTZARES				23B. DATE SIGNED 12-2-71		23C. PHYSICIAN'S NAME (Type) R. CAUTZARES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/71		24C. NAME OF CEMETERY or CREMATORY Landon Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR John E. Taylor & Son Inc.		ADDRESS 21003 Hollins St.			

FUNERAL DIRECTOR: IMPORTANT

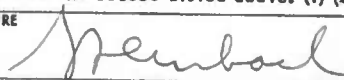
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

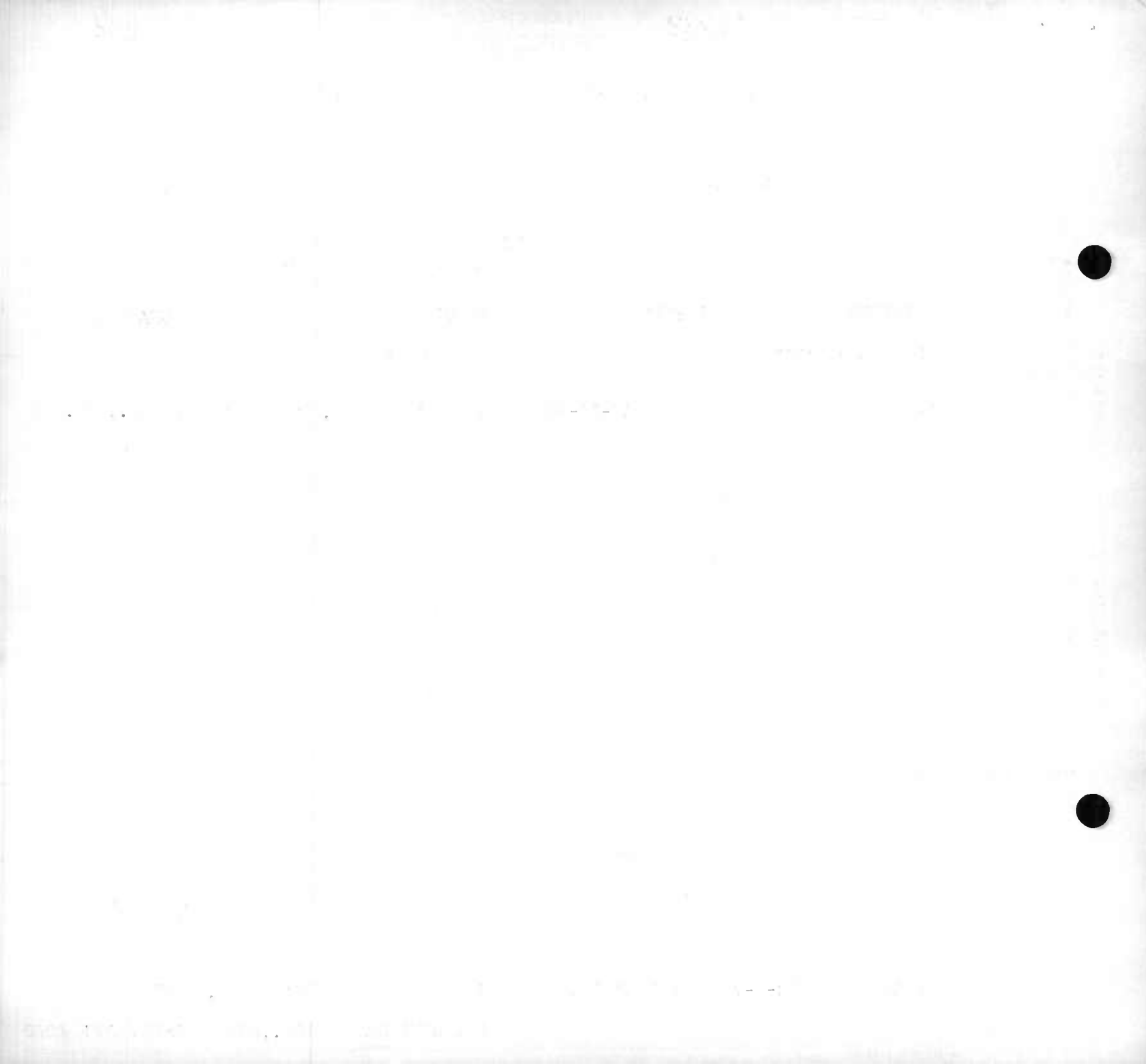
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 11231</u>
BIRTH NO. <u>M-538</u>		71 11231		
1. NAME OF DECEASED (Type or Print) <u>SARA K. MINDEL</u>		2. DATE AND HOUR OF DEATH <u>12/1/71</u> <u>8:55 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6652 SANZO ROAD</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-15</u>	9. AGE (In years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD, BALTIMORE</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ISAAC KEYSER</u>		
14. MOTHER'S MAIDEN NAME <u>MOLLIE RANKIN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>214-01-8042</u>		17. INFORMANT ADDRESS <u>MR. NATHAN MINDEL, 6652 SANZO RD., APT. D #9</u>		
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Carcinoma of Breast</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Requid Ovarian Tumor</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Requid Ovarian Tumor</u>				
19A. DATE OF OPERATION <u>1</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>YES</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> 19 <u>71</u> to <u>12/1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Arthur A. Serpick</u>		23B. DATE SIGNED <u>12/1/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Arthur A. Serpick</u>		23D. ADDRESS <u>1114 Saint Paul St. Balto 2202</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>12-3-71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>HEBREW YOUNG MEN</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1971</u>		25B. NAME OF REGISTRAR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		
25C. FUNERAL DIRECTOR ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

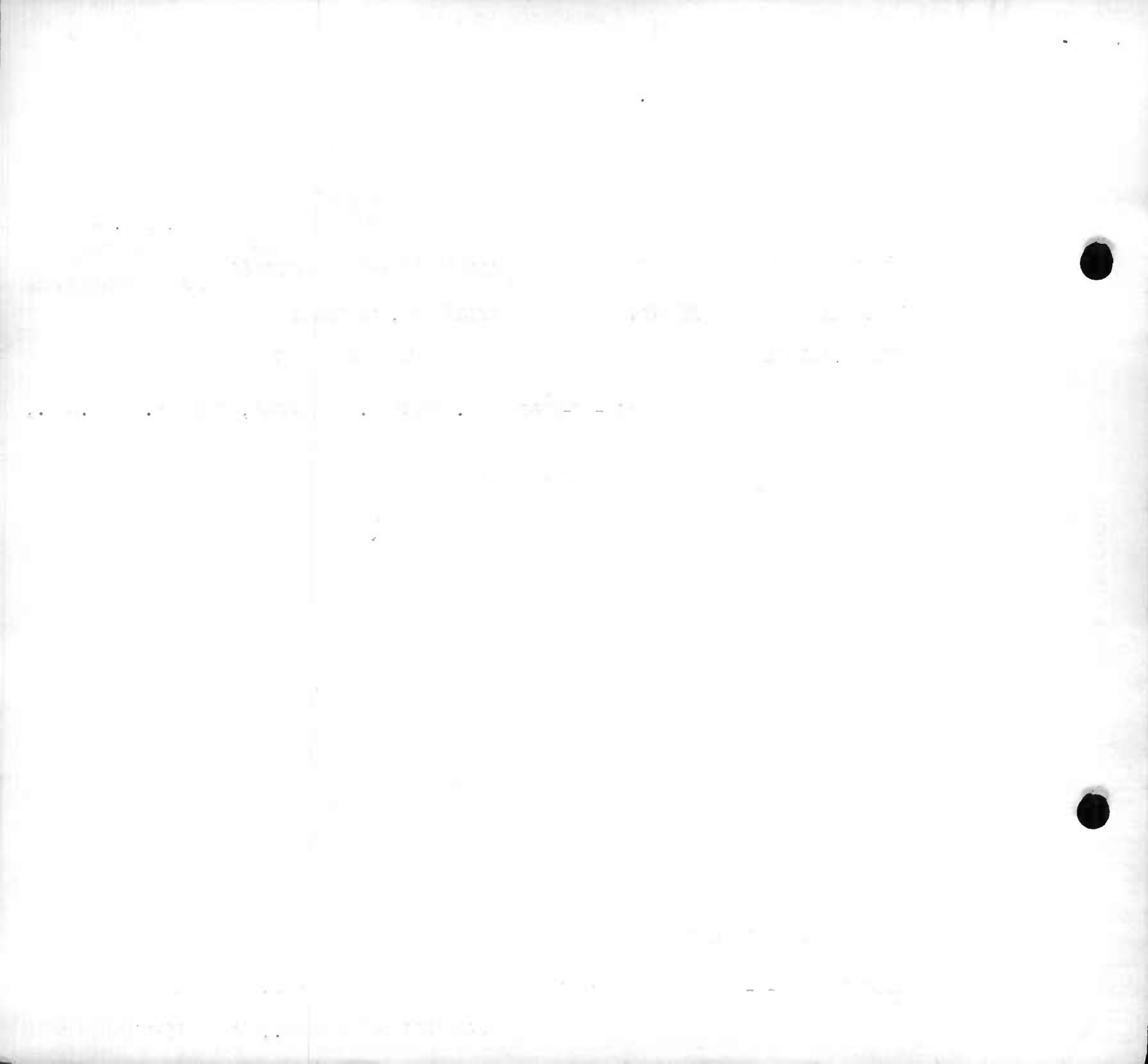
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11232	
K-235 71 11232 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Kesten, Samuel MAX		2. DATE AND HOUR OF DEATH 12/1/71 1925pm			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hosp		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO 5. CITY OR TOWN BALT. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6960 Brookmill Rd.			
5. SEX MALE 6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/27/01 9. AGE (in years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME CHAIM BEN DAVID		14. MOTHER'S MAIDEN NAME REGINIA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-14-4694		17. INFORMANT MISS ROSE KESTEN, 6960 BROOKMILL RD., APT. 2B ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction 24 hrs. ANTECEDENT CAUSES (B) Coronary Artery disease DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19__ to 19__ that (I) (we) last saw the deceased alive on 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 12/1/71		23C. PHYSICIAN'S NAME (Type) DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-3-71		24C. NAME of CEMETERY or CREMATORY CHEVRA AHAVAS CHESSED	
24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971 25B. NAME OF REGISTRAR Robert E. Sabin, M.D.			
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8-530 71 11233		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11233	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Smith Fannie R		December 2, 1971 5:29 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md. Baltimore		2730	
Sinai Hospital of Baltimore Inc.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Belvedere at Hooespring		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
HOUSEWIFE		AT HOME		XXXXXX XXXXX	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)	
IKE ROSENTHAL		THERESA ?		XXXX 86	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
NO		216-03-5603		BALTIMORE, MARYLAND	
17. INFORMANT		18. CAUSE OF DEATH		12. CITIZEN OF WHAT COUNTRY?	
MRS. JANIS H. GREENHOOD, 7233 PK. HIGHTS AVE.,		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		U.S.A.	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Pulmonary edema		10 minutes	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		3 days	
		Pulmonary heart disease			
		(C) DUE TO, OR AS A CONSEQUENCE OF:		years	
		Heart disease			
MEDICAL CERTIFICATION		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11-30 1971 to 12-2 1971 that (I) (we) last saw the deceased alive on 12-2 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Jack Pollack M.D.		December 2, 1971			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JACK POLLACK					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		12-3-71		LOUDON PARK	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
BALTIMORE, MARYLAND		DEC 6 1971		Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS			
SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

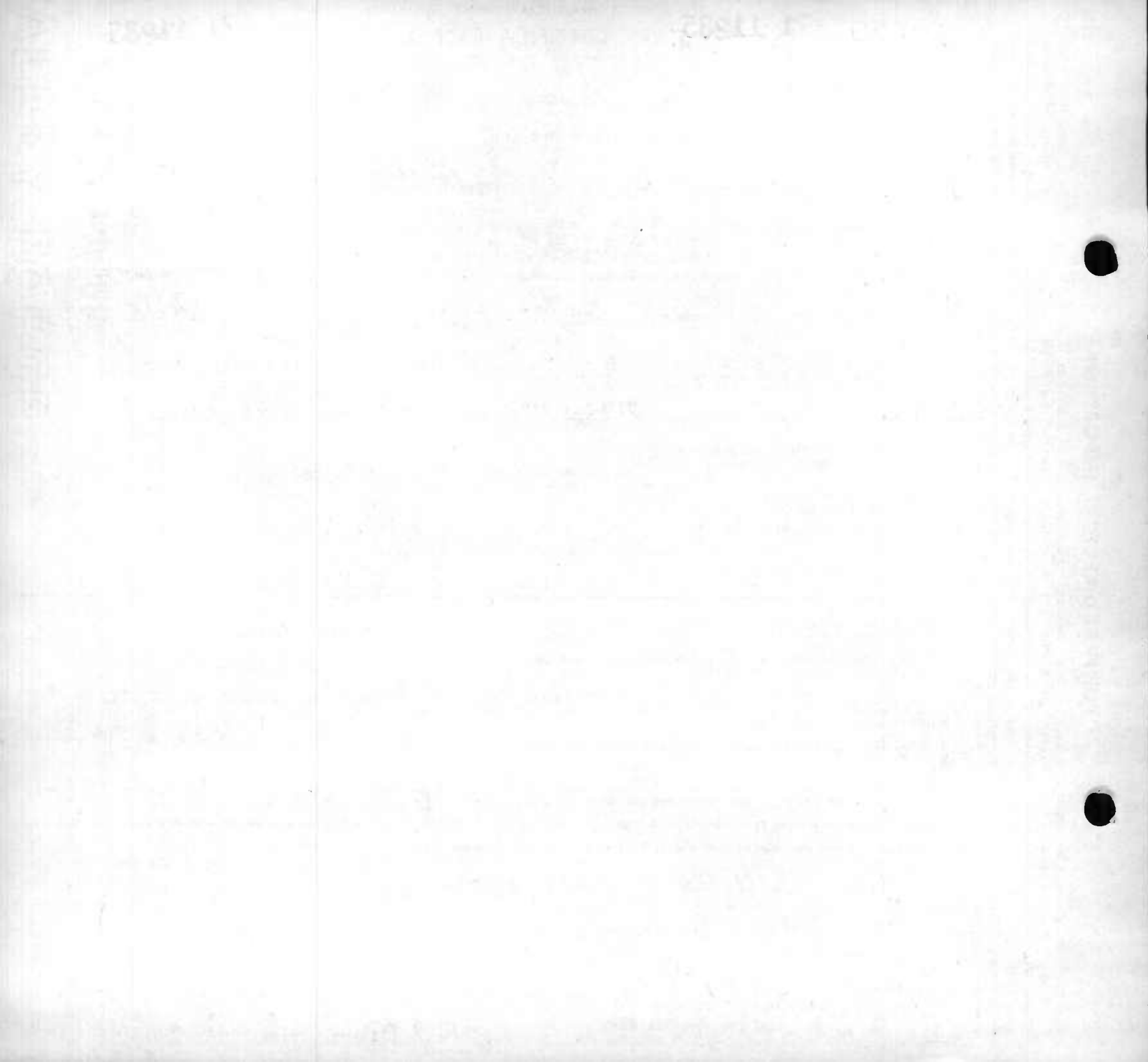
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11234</u>	
<div style="display: flex; justify-content: space-between;"> R-250 71 11234 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) PAUL ROSEN			2. DATE AND HOUR OF DEATH 12/2/71 12:47 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSP BALTO., MD.			A. STATE MARYLAND 8. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6308 IVYMOUNT ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/19/02	9. AGE (in years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED			10B. KIND OF BUSINESS OR INDUSTRY MANUFACTURE		
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME MYRON LOUISA ROSEN			14. MOTHER'S MAIDEN NAME KATIE GOLDSTEIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 217 09 3304		
17. INFORMANT MRS. LILLIAN ROSEN, 6308 IVYMOUNT RD. #21209			ADDRESS		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 11/25			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11/25 19 71 to 12/2 19 71 and that (I) (we) last saw the deceased alive on 12/2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Feinglass, M.D.			23B. DATE SIGNED 12/2/71		
23C. PHYSICIAN'S NAME (Type) E. FEINGLASS M.D.			23D. ADDRESS The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-3-71	24C. NAME of CEMETERY or CREMATORY BNAI ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971			25B. NAME OF REGISTRAR E. Feinglass, M.D.		
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

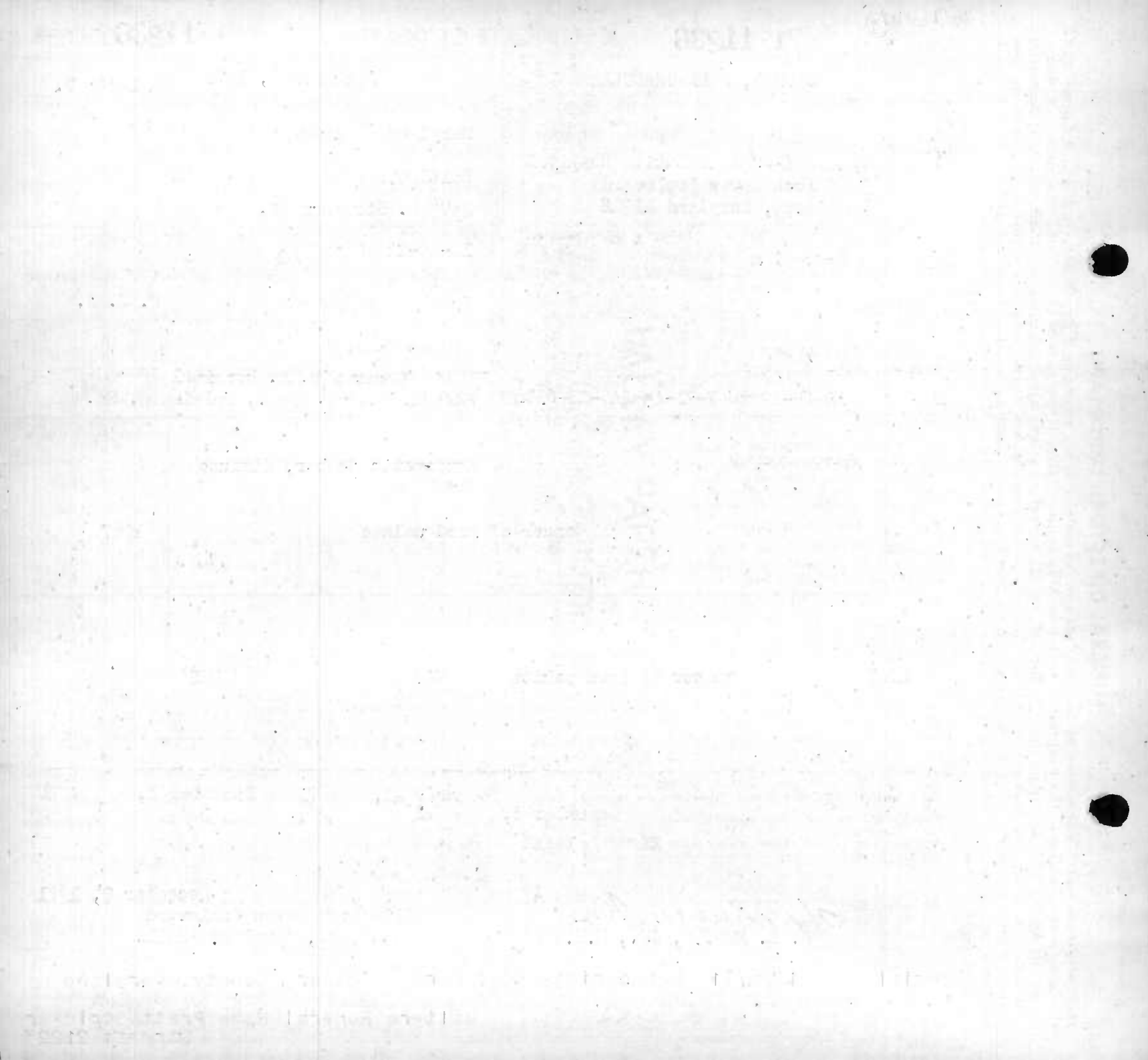
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-600 71 11235				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11235	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Richard W. Berry</u>				2. DATE AND HOUR OF DEATH <u>12/3/71</u> <u>7 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2102</u>			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>841 Washington Blvd</u>				E. STREET AND NUMBER <u>841 Washington Blvd. 21230</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Separated</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/30/1908</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Glen L. Martin</u>		11. BIRTHPLACE (State or foreign country) <u>Balt. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Berry</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Steiner</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>317-05-7842</u>		17. INFORMANT <u>Helen Brooks - 841 Washington Blvd.</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>492X 1571.0</u>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Cor Pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 week</u>	
				(B) <u>Pulmonary Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>2 yrs</u>	
				(C) <u>Cirrhosis of Liver</u>		<u>2 yrs</u>	
II				<u>Chronic Alcoholism</u>		<u>15 years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> 19 <u>70</u> to <u>12/3</u> 19 <u>71</u> , that (I) (we) lost saw the deceased alive on <u>11/24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John P. Urlock Jr MD</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12-3-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN P URLOCK JR MD</u>				23D. ADDRESS <u>1227 Washington Blvd</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>12/7/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Glenburnie, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Brown, Inc. Inc. 90, Hallens St</u>		ADDRESS <u>Balt. Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11236	
BIRTH NO. C-200		71 11236		1. NAME OF DECEASED (Type or Print) CAUSEY, JOHN CHANDLER		2. DATE AND HOUR OF DEATH December 1, 1971 10:25 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				A. STATE B. COUNTY Maryland Baltimore			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 237 1/2 S. Stricker St.				1902			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-19-22	9. AGE (In years last birthday) 48	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abraham Causey				14. MOTHER'S MAIDEN NAME Flora Causey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12-19-42 to 7-21-45				16. SOCIAL SECURITY NO. 247-28-8376		17. INFORMANT Records V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic cancer, diffuse 145.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cancer of hard palate 1967				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1967			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cancer of hard palate		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from November 11, 1971 to December 1, 1971, that (X) (we) last saw the deceased alive on December 1, 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. L. MUNCIE, JR., M.D.				23B. DATE SIGNED December 2, 1971		23C. PHYSICIAN'S NAME (Type) H. L. MUNCIE, JR., M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/71		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park		24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Stricker Streets 21223			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-620 71 11237		Baltimore City Health Department		REG. NO. 71 11237	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		YORK, RUDOLPH		DECEMBER 2, 1971 8:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVE		A. STATE MARYLAND B. COUNTY ANNE ARUNDEL 5200	
5. SEX MALE		6. RACE CAUCASION		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/20/22		9. AGE (in years last birthday) 49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BUILDER		R & D BUILDERS		OHIO	
12. CITIZEN OF WHAT COUNTRY? XXX U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
ROLAND YORK		HELEN KELLER YORK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
WW 2		216 18 9249		BALTIMORE MARYLAND ADDRESS 21229	
				ST AGNES HOSPITAL CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Acute Myocardial Infarction, extensive		6 hours	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Coronary thrombosis of Right Coronary artery and Left Anterior Descending complete			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Cathero-clerotic Cardiovascular Disease			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 2 1971 to DECEMBER 2 1971 that (X) (we) last saw the deceased alive on DECEMBER 2 19 71 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (We) (did) XXXXXX view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12/6/71		Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Ritchie Highway Glen Burnie Md.		DEC 6 1971		McGully Funeral Home 237 Patapsco Ave 21225	
25C. FUNERAL DIRECTOR		25D. ADDRESS			
McGully Funeral Home 237 Patapsco Ave 21225					

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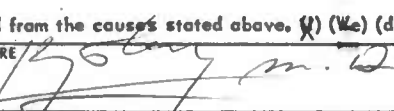
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BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JOSEPH HIRSCH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 2, 1971 9:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year December 2, 1971 9:45 P. M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2741	
7. RACE White		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 4017 Ridgcroft Road	
9. DATE OF BIRTH Jan. 18, 21		10. AGE (In years lost birthday) 50	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME August		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Anna Rolle	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.2 Army		17. SOCIAL SECURITY NO.	
18. INFORMANT John Hirsch		ADDRESS 21206 4717 Greenhill Ave.	
19. 571.9 I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) (Partial) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 6, 71	
24C. NAME OF CEMETERY or CREMATORY Holy Redemer		24D. LOCATION (City, town, or county) (State) Balto City	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert S. Taylor, M.D.	
25C. FUNERAL DIRECTOR P. A. Heemann		ADDRESS 6067 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11239	
C-510 71 11239 BIRTH NO. 1. NAME OF DECEASED (Type or Print) CANBY, ROBERT ARTHUR		2. DATE AND HOUR OF DEATH 12-10-71 9:00AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MARYLAND 21230		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21230 2572 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2502 BROHAWN AVE BALTO MD			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-24-13	9. AGE (In years last birthday) 58	10. Under 1 Yr. Months: Days 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ARTHUR CANBY		14. MOTHER'S MAIDEN NAME ANNIE BOLDEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-3039		17. INFORMANT BALTO MD 21229 ST. AGNES' RECORDS-CATON & WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 431.94 250.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Brain hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Diabetes mellitus			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Specify) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11-29-71 to 11-30-71 that (X) (we) last saw the deceased alive on NOVEMBER 30 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) JOSE APTER				23B. DATE SIGNED 11-30-71	
23D. ADDRESS BALTO MD 21229 ST. AGNES HOSPITAL-WILKENS & CATON AVE.		23E. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/71		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971			
25B. NAME OF REGISTRAR Edw. S. MacNabb Sons, Inc.		25C. FUNERAL DIRECTOR 301 Frederick Rd. Catonsville, Md.			

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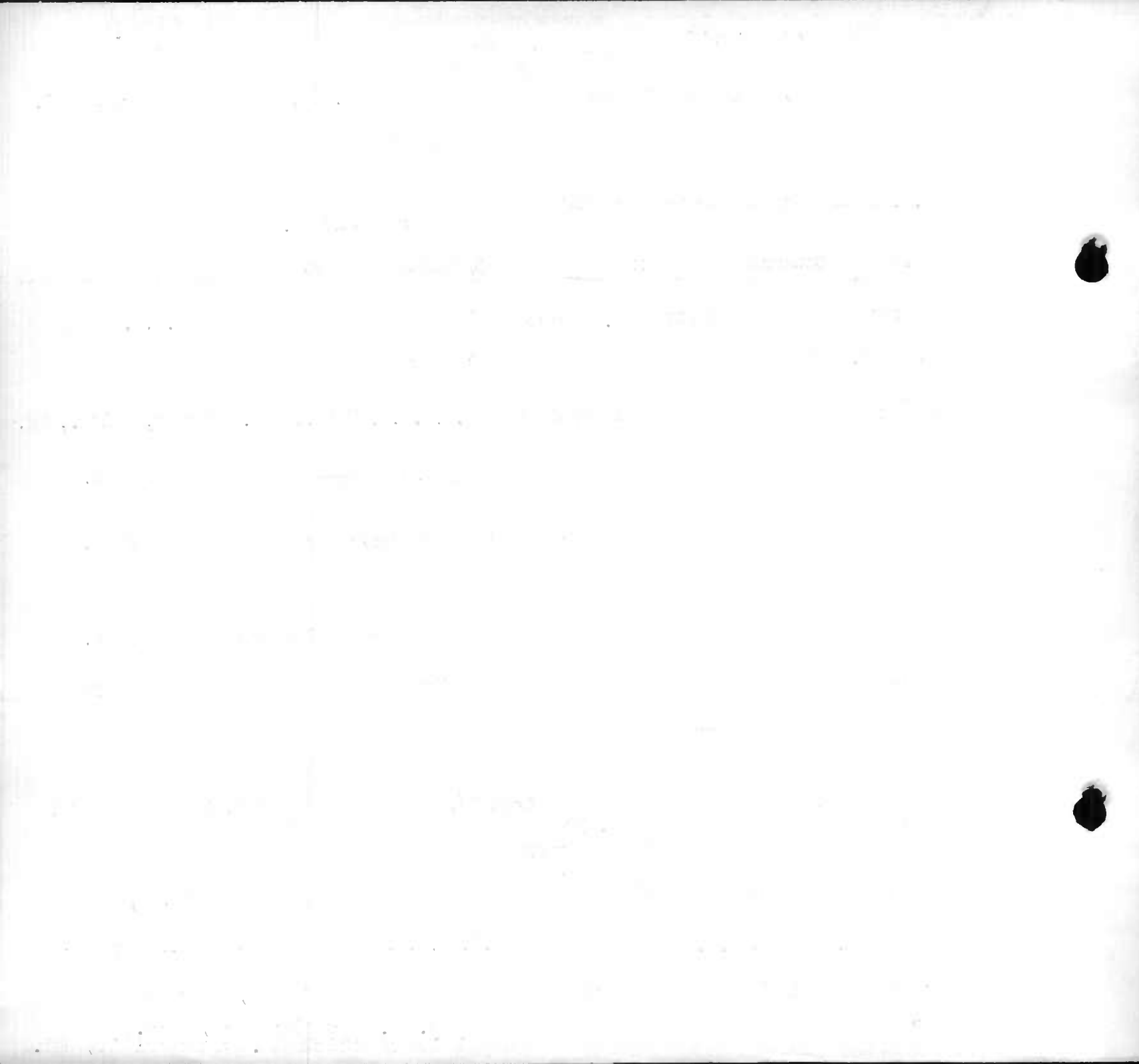
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11240	
M-324 71 11240 BIRTH NO.		71 11240 2. DATE AND HOUR OF DEATH Nov. 30, 1971 6:30 P.M.			
1. NAME OF DECEASED (Type or Print) Metcalf, Benjamin Franklin		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD U.S. Public Health Service Hospital			
FULL NAME OF HOSPITAL OR INSTITUTION U.S. Public Health Service Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 108 West Towne Rd.			
5. SEX Male 6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Appt. House		8. DATE OF BIRTH 3/5/1896 9. AGE (In years last birthday) 75 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John R. Metcalf		14. MOTHER'S MAIDEN NAME Ida Bryan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 215 07 4571		17. INFORMANT ADDRESS U.S.P.H.S. Hosp., Med. Records, Balto., Md.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 7 da.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Possible bronchogenic carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF:				3 mo.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Thrombosis of Superior Vena Cava				3 mo.	
19A. DATE OF OPERATION 2 --		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Inletly medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---	
22. I certify that (If this hospital) attended the deceased from Sept 29, 1971 to Nov. 30, 1971 that (I) (we) last saw the deceased alive on Nov. 30, 1971 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert R. Wright, M.D.				23B. DATE SIGNED Dec. 1, 1971	
23C. PHYSICIAN'S NAME (Type) Robert R. Wright, M.D.		23D. ADDRESS U.S. P.H.S. Hospital, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/71		24C. NAME of CEMETERY or CREMATORY Western	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971			
25B. NAME OF REGISTRAR Edw. S. MacNabb Sons, Inc.		25C. FUNERAL DIRECTOR ADDRESS 301 Frederick Rd. Catonsville, Md.			



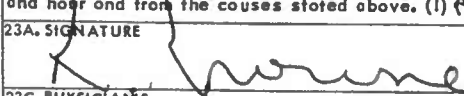
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

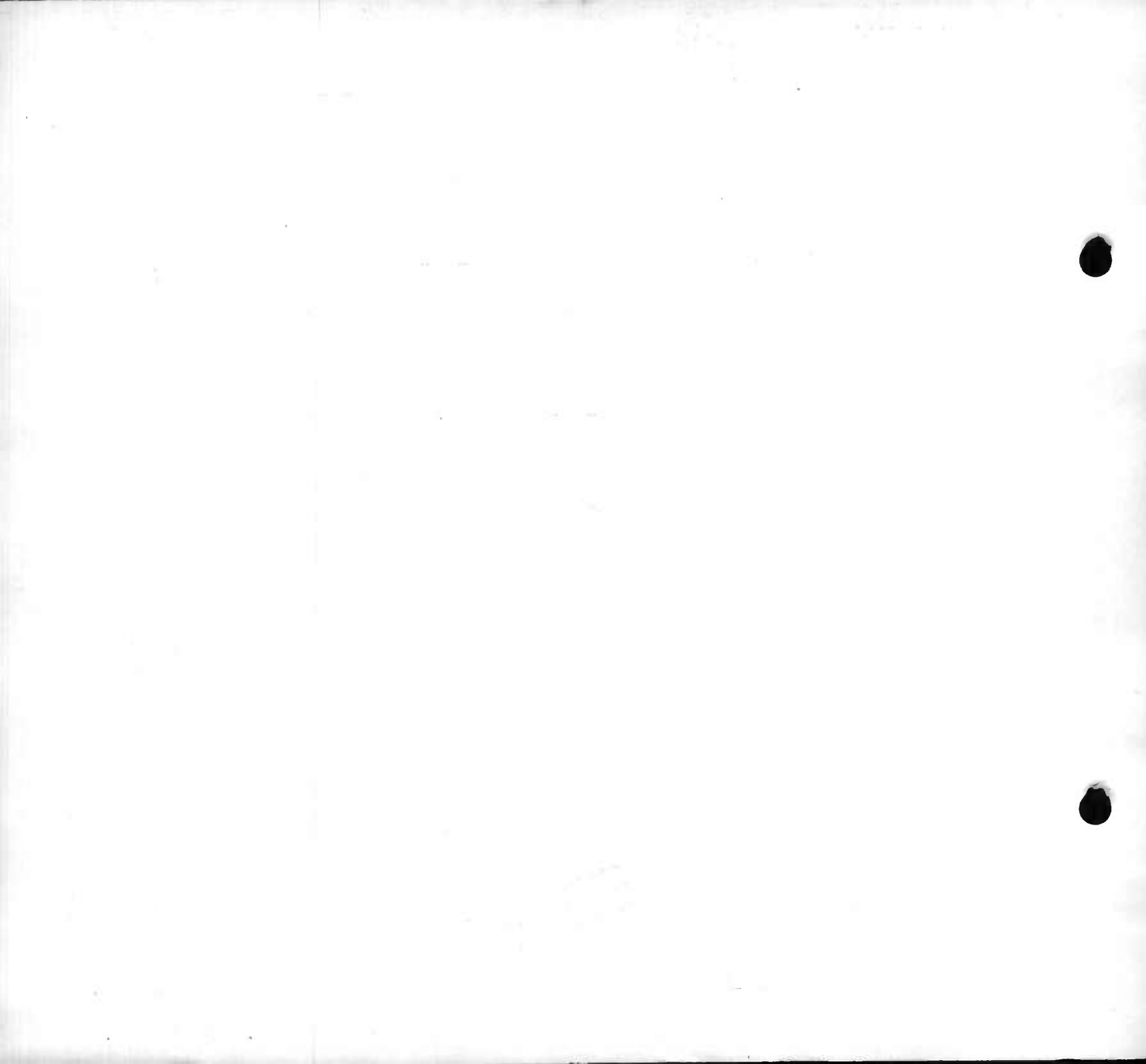
M-622 71 11241		BALTIMORE CITY HEALTH DEPARTMENT		71 11241	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>ANTIONETTE MARKOWSKI</i>		2. DATE AND HOUR OF DEATH <i>12/7/71 6:15 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE <i>MD.</i> B. COUNTY <i>201</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Caucasian</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>9/20/1895</i>	
13. FATHER'S NAME <i>ADAM CWALESKA</i>		14. MOTHER'S MAIDEN NAME <i>ANNA OBRYSKA</i>		9. AGE (In years last birthday) <i>76</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>220-14-1957A</i>		11. BIRTHPLACE (State or foreign country) <i>POLAND</i>	
17. INFORMANT <i>BCH: Records Baltimore, Maryland 21224</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		18. CAUSE OF DEATH <i>412.4 I</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ATHEROSCLEROTIC CORONARY DISEASE</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>10/18/71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Biliary Stone</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/29/71</i> 19 <i>71</i> to <i>12/4/71</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>12/4/71</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ronald Banks</i>		23B. DATE SIGNED <i>12/4/71</i>		23C. PHYSICIAN'S NAME (Type) <i>RONALD BANKS</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12-7-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>HOLY ROSARY CEM.</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO, DUNDALK MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 6 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>	
25C. FUNERAL DIRECTOR <i>John M. Weber & Sons Inc. S. Chester</i>		25D. ADDRESS <i>401</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

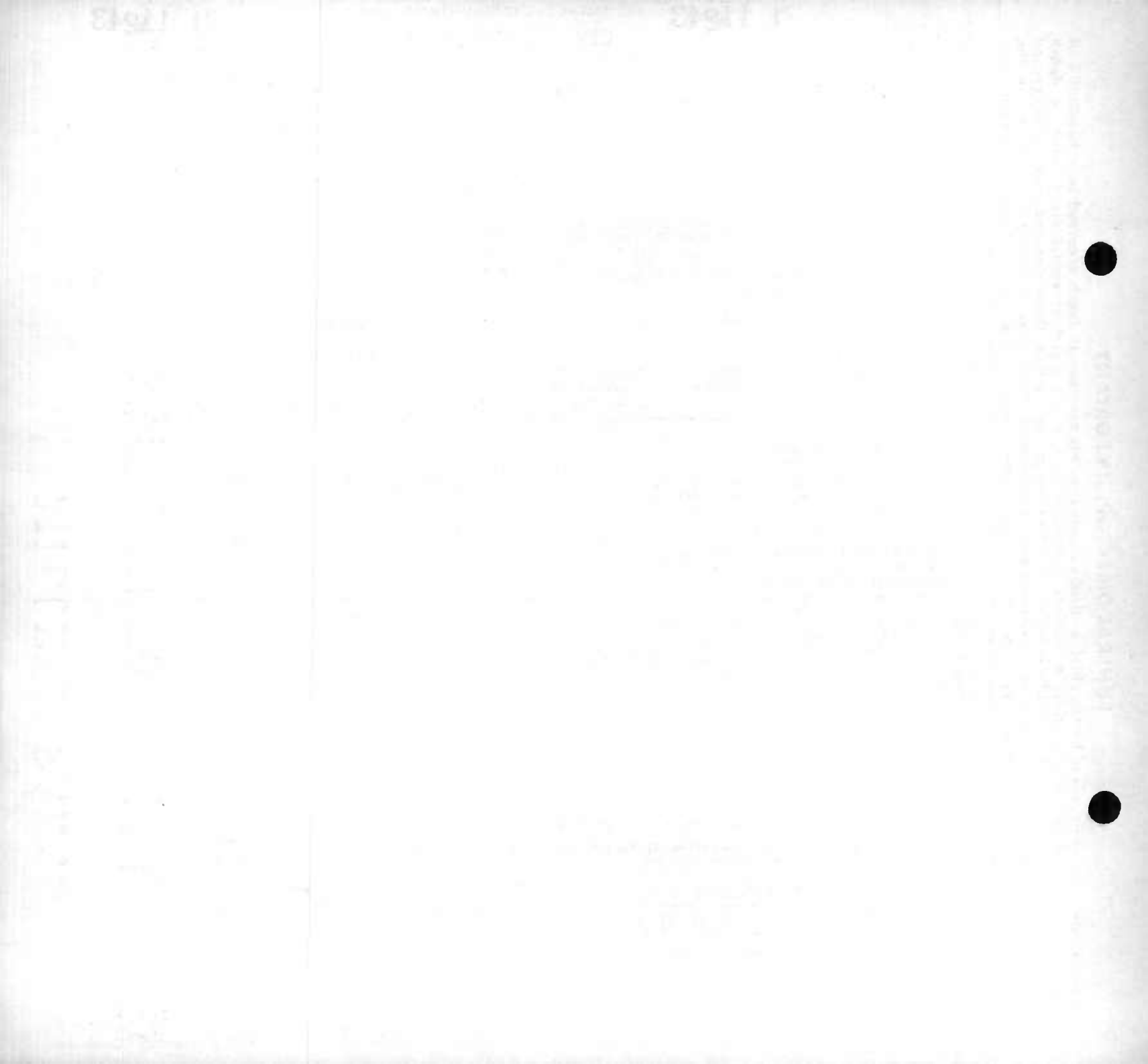
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11242	
P-400 71 11242				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) H. Wallace Peele		2. DATE AND HOUR OF DEATH 12-3-71 12:AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY 908			
FULL NAME OF HOSPITAL OR INSTITUTION 2234 Cecil Ave.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Construction		8. DATE OF BIRTH 7-10-97	
13. FATHER'S NAME John Peele		14. MOTHER'S MAIDEN NAME Waydie Calvert		9. AGE (in years last birthday) 74	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 229-01-5884		17. INFORMANT Mrs. Olia Thorpe NYC	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.4 & 250.9		CAUSE OF DEATH St. C. V. Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1965	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Drabetes mellitus		(B) DUE TO, OR AS A CONSEQUENCE OF: 1969	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Drabetes mellitus		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 1965 to Dec 1971 that (I) (we) last saw the deceased alive on 7/21 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 12-6-71	
23C. PHYSICIAN'S NAME (Type) RAYNER BARRY		23D. ADDRESS 1500 EAST MADISON ST. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71		24C. NAME of CEMETERY or CREMATOR Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm C March		25D. ADDRESS 928 E. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-536 71 11243				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11243	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Sanders, John W.</i>				2. DATE AND HOUR OF DEATH <i>12/1/71 0-05 AM</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>MONROE ST 1604</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> <i>43</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/30</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>L</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>39</i>		11. BIRTHPLACE (State or foreign country) <i>Birmingham Ala</i>	
13. FATHER'S NAME <i>Charles Sanders</i>				14. MOTHER'S MAIDEN NAME <i>ELIZAYOUNG</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-28-930</i>		17. INFORMANT <i>Margaret Buffe</i>		ADDRESS <i>7637 Monro</i>	
18. <i>199.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Malignant Cachexia.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11-23</i> 19 <i>71</i> to <i>12-1</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>12-1</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>C. S. S. S.</i>				23B. DATE SIGNED <i>12/1/71</i>		23C. PHYSICIAN'S NAME (Type) <i>P-SUBBARAO</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>12-4-71</i>		24C. NAME of CEMETERY or CREMATORY <i>McGowan</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 6 1971</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Sarah L. Brown</i>	
24D. LOCATION <i>BALTI. MD</i>				25D. ADDRESS <i>1234 W. Main St</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11244	
BIRTH NO. 71 11244				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>REUBEN WARREN HAMMER SLOUGH</u>			2. DATE AND HOUR OF DEATH <u>NOV 29 1971 7:20 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1102</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MD GEN HOSP 12/6/71</u>			C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>101 W. MONUMENT ST 21201</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5, 1884</u>	9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired = Recorder of</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Boumi Temple</u>		11. BIRTHPLACE (State or foreign country) <u>M.D.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Julian Hammerslough</u>			
14. MOTHER'S MAIDEN NAME <u>Cecilia (Myers)</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO None</u>			
16. SOCIAL SECURITY NO. <u>220-09-5909</u>		17. INFORMANT <u>10019 Lorain Ave. Silver Springs, Md</u> <u>Mr. and Mrs. Richard H. Palmer 20901</u>			
18. <u>600X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>UREMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>OBSTRUCTIVE UROPATHY</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>BENIGN PROSTATIC HYPERTROPHY</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>6 MONTHS</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>28 NOV 19 71</u> to <u>29 NOV 19 71</u> that (I) (we) last saw the deceased alive on <u>29 NOV 19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Shepherd Kahan</u>					23B. DATE SIGNED <u>29 NOV 71</u>
23C. PHYSICIAN'S NAME (Type) <u>SHEPHERD KAHAN MD</u>					23D. ADDRESS <u>MD GEN HOSP</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/2/1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Trinity Church Cemetery</u>	
24D. LOCATION <u>Arlington, Nelson County, Virginia</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1971</u>		25B. NAME OF REGISTRAR <u>Robt E. Gabe, M.D.</u>		25C. FUNERAL DIRECTOR <u>Loring Byers Funeral Directors, Pa.</u>	

12/6/71 - Correction form from funeral director.

Labe

H 536

71 11245

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11245

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JEAN ALLEN HUNTER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year December 1, 1971 Hour 3:45 A.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct. 15, 1930		10. AGE (In years lost birthday) 41	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Bessie Rainey		18. INFORMANT Catherine Y. Pettus - 2568 Hollins St.	
19. 571.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Cirrhosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71	
24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.	
25C. FUNERAL DIRECTOR Mary-Elizabeth Law		ADDRESS 802 Madison Ave.	

1951

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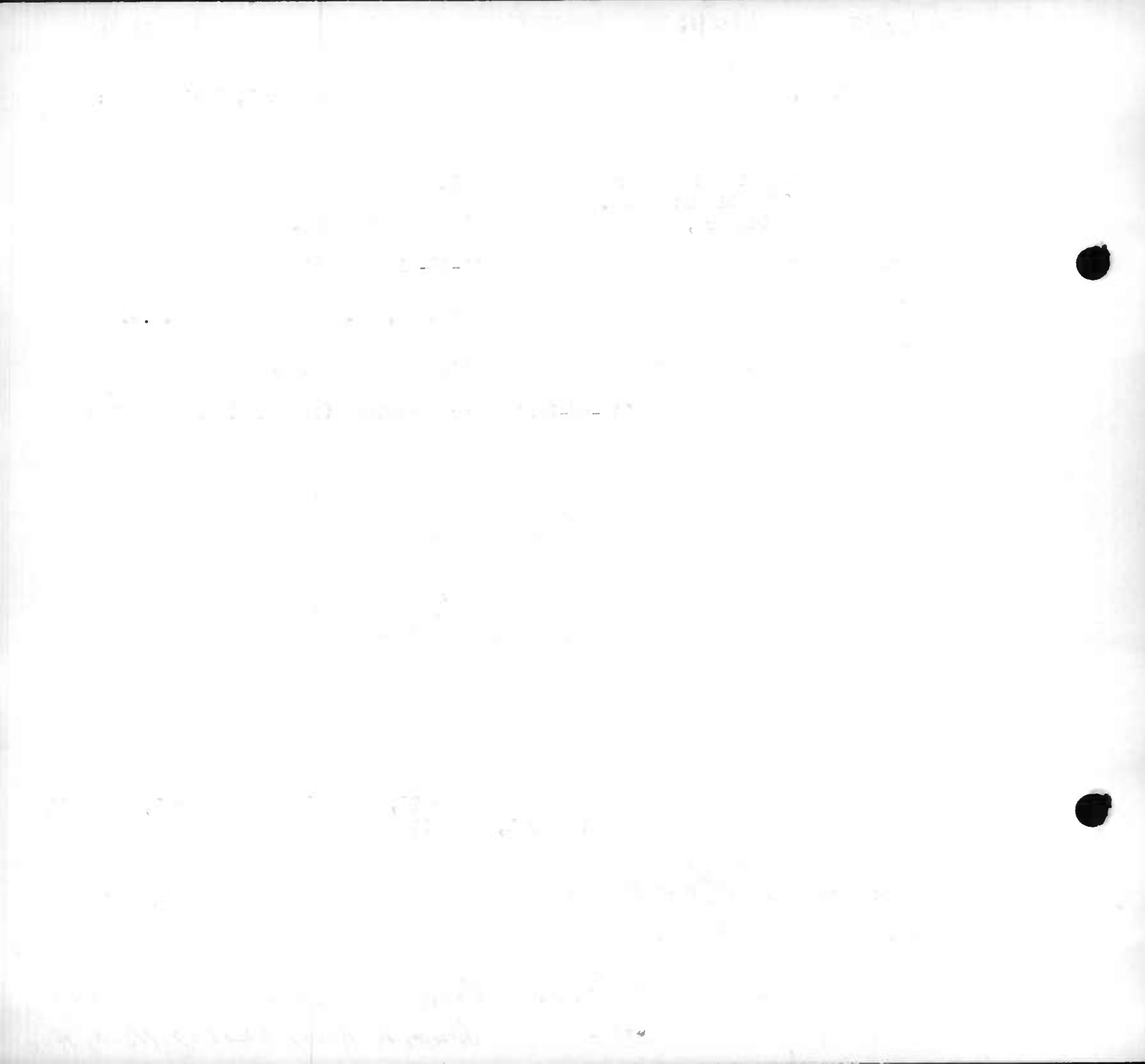
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

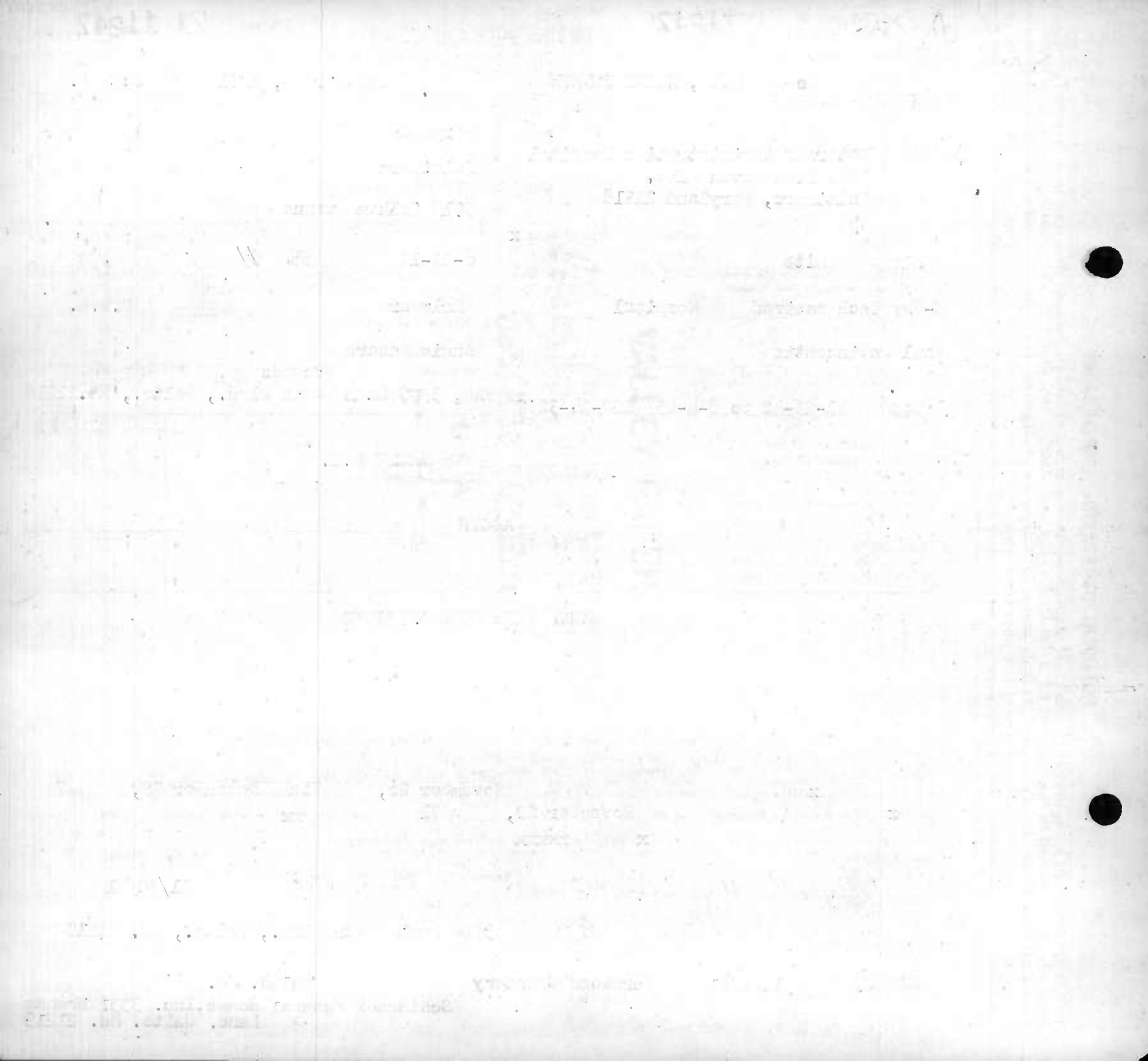
W-623 71 11246		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11246	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Wright, Mary		2. DATE AND HOUR OF DEATH December 2, 1971 8:05 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1504		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 2600 Liberty Hgts. Baltimore, Md		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1909 Wheeler Ave.	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-84	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Eastern, Md.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Walter J. Moore		14. MOTHER'S MAIDEN NAME Anna Bigall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-7994		17. INFORMANT Mary Harrison (Daughter) 1909 Wheeler Ave	
18. 44091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GENERALIZED ARTERIOSCLEROSIS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SENILITY (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). RENAL FAILURE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from November 27, 19 71 to December 2, 19 71 that (I) (we) last saw the deceased alive on December 2, 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Gilbert L. Bankfield		23B. DATE SIGNED 12/2/71		23C. PHYSICIAN'S NAME (Type) GILBERT L. BANKFIELD M.D.	
23D. ADDRESS 722 N. Fulton AVE BALT 247.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		24D. LOCATION (City, town, or county) (State) Westport Md		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971	
25B. NAME OF REGISTRAR Robert E. Fisher, Md.		25C. FUNERAL DIRECTOR Joseph H. Run		25D. ADDRESS 2222 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

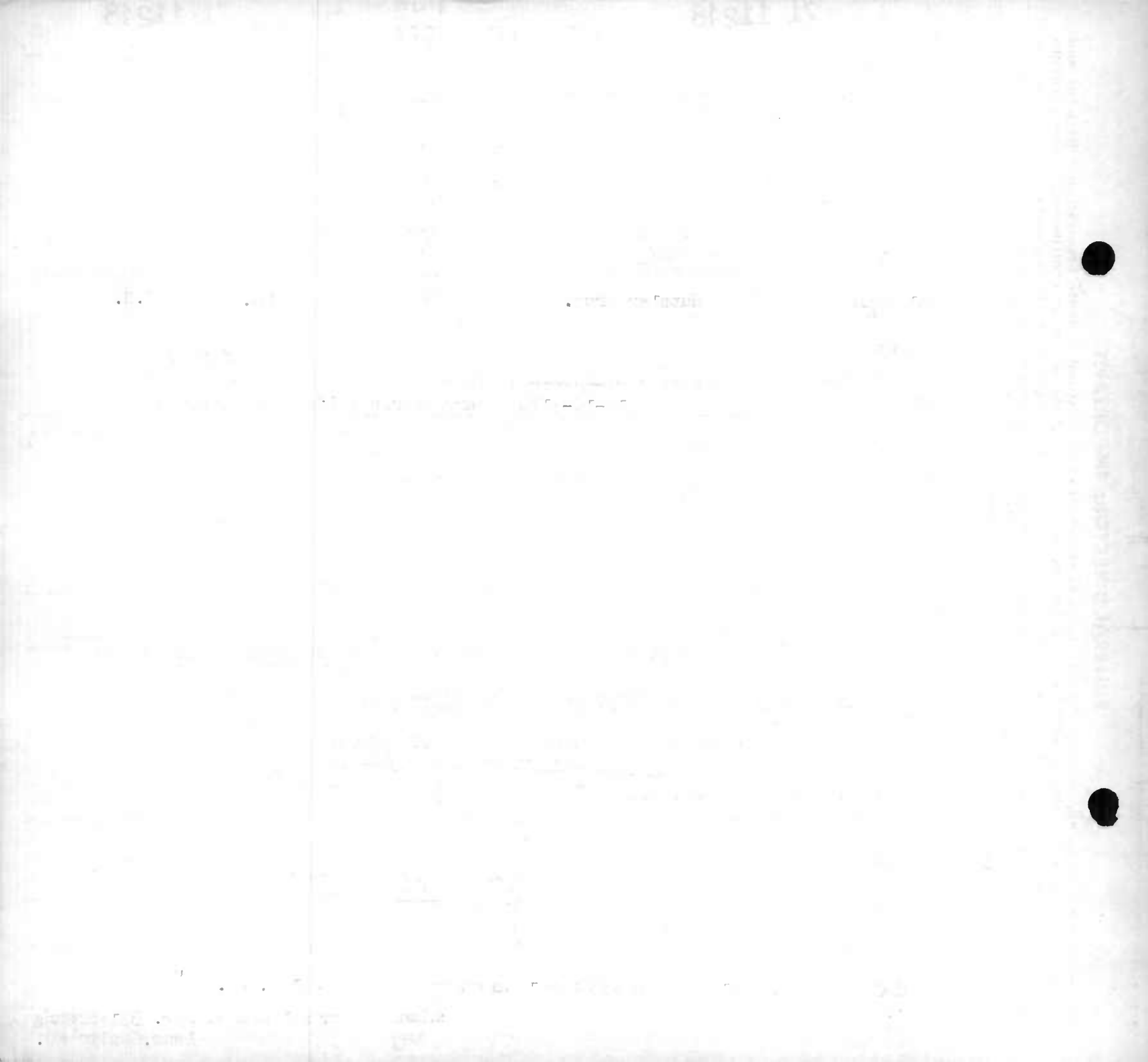
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11247	
BIRTH NO. D-152		71 11247	
1. NAME OF DECEASED (Type or Print) DEVINCENTIS, HARRY JOSEPH		2. DATE AND HOUR OF DEATH November 29, 1971 6:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2633	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3215 Pelham Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-16
9. AGE (In years last birthday) 55		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X-Ray Tech retired		10B. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul DeVincentis		14. MOTHER'S MAIDEN NAME Annie Azzaro	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-25-42 to 8-4-43		16. SOCIAL SECURITY NO. 160-14-3252	
17. INFORMANT Records ADDRESS VAH, 3900 Loch Raven Blvd., Balto., Md. 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.94-250.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE M.I.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). COPD DIABETES MELLITUS		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that 05 (this hospital) attended the deceased from November 26, 1971 to November 29, 1971 , that 05 (we) last saw the deceased alive on November 29, 1971 and that in 000 (our) opinion death occurred on the date and hour and from the causes stated above. 05 (We) (did) XXXXXX view the body after death.			
23A. SIGNATURE Meyer R. Heyman MD		23B. DATE SIGNED 11/30/71	
23C. PHYSICIAN'S NAME (Type) MEYER R. HEYMAN MD		23D. ADDRESS 3900 Loch Raven Blvd., Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12/4/71	24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11248	
<div style="display: flex; justify-content: space-between;"> B-620 71 11248 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) EDWARD BOURKE		2. DATE AND HOUR OF DEATH 12-2-71 0.10 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE MARYLAND		B. COUNTY COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
44		E. STREET AND NUMBER 3837 LYNDALE AVE		2643	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-17-07	9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Hutzler Bros.		11. BIRTHPLACE (State or foreign country) AMERICAN Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Bernard BOURKE			14. MOTHER'S MAIDEN NAME AGNES Murphy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-10-3176		17. INFORMANT Mary Bourke (wife) same address	
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p>5-21-8 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE CARDIAC ARREST</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) BILIARY CIRRHOSIS</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> </div> <div style="flex: 0.5;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
19A. DATE OF OPERATION					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-1-71 to 12-2-71		that (I) (we) last saw the deceased alive on 12-1-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Juan M. Calderon				23B. DATE SIGNED 12-2-71	
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON M.D.				23D. ADDRESS UHH	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		12/1/71		New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 6 1971		Robert E. Gable, M.D.		Schimunek Funeral Homes, Inc. 331 Brehms Lane, Balto Md.	



B-361

71

11249

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11249

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)E.
ROBERT BUTTERFIELD2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

December 3, 1971

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

December 3, 1971

2:30 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

Anne Arundel

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

LINTHICUM

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

3-27-1913

10. AGE (In years
last birthday)

58

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

515 Sudbury Road

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Edward R. Butterfield

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Office Manager

14B. KIND OF BUSINESS OR INDUSTRY

Crocker & Stallings

15. MOTHER'S MAIDEN NAME

Tyler Field

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

213-05-4994

18. INFORMANT

ADDRESS

21090

Mrs. Bertha R. Butterfield, 515 Sudbury Rd.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 3, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-6-1971

24C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

24D. LOCATION (City, town, or county)

Woodlawn, Maryland

25A. DATE REG'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 6 1971

Robert E. Johnson, Jr.

Howard H. Hubbard, 4107 Wilkens Ave. 21229

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71 11250

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11250

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ellsworth H. Kerbe				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 2 71 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 2 71 3:50 a.m.			
6. SEX male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2003	
9. DATE OF BIRTH 12-27-1921		10. AGE (In years last birthday) 49		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred H. Kerbe		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto. Mechanic		15. MOTHER'S MAIDEN NAME Florence Boston		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 213-14-2167		18. INFORMANT Mr. Alfred C. Kerbe, 625 S. Pulaski St. 21223		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/2/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-1971		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park		24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Myrtle Louise Blue		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Day 2 Year 71 Estimated <input type="checkbox"/> Hour 6:50 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Balto. City Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month 12 Day 2 Year 71 Hour 6:50 a. M.	
6. SEX female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12-25-39		10. AGE (In years last birthday) 32 31	
11. BIRTHPLACE (State or foreign country) Ward W, Va		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		14B. KIND OF BUSINESS OR INDUSTRY home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 220 36 9386	
18. INFORMANT James Blue U S Air Force		ADDRESS	
19. E890X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Carbon monoxide poisoning and soot inhalation (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME	
22D. TIME OF INJURY (APPROX.) Month 12 Day 2 Year 71 Hour 5:46 a. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1220 Steelton Avenue		22F. HOW DID INJURY OCCUR? Subject in house fire.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/2/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Jolley, M.D.	
25C. FUNERAL DIRECTOR WALTER DABROWSKI		ADDRESS 1005 DUNDALK ACENUE	

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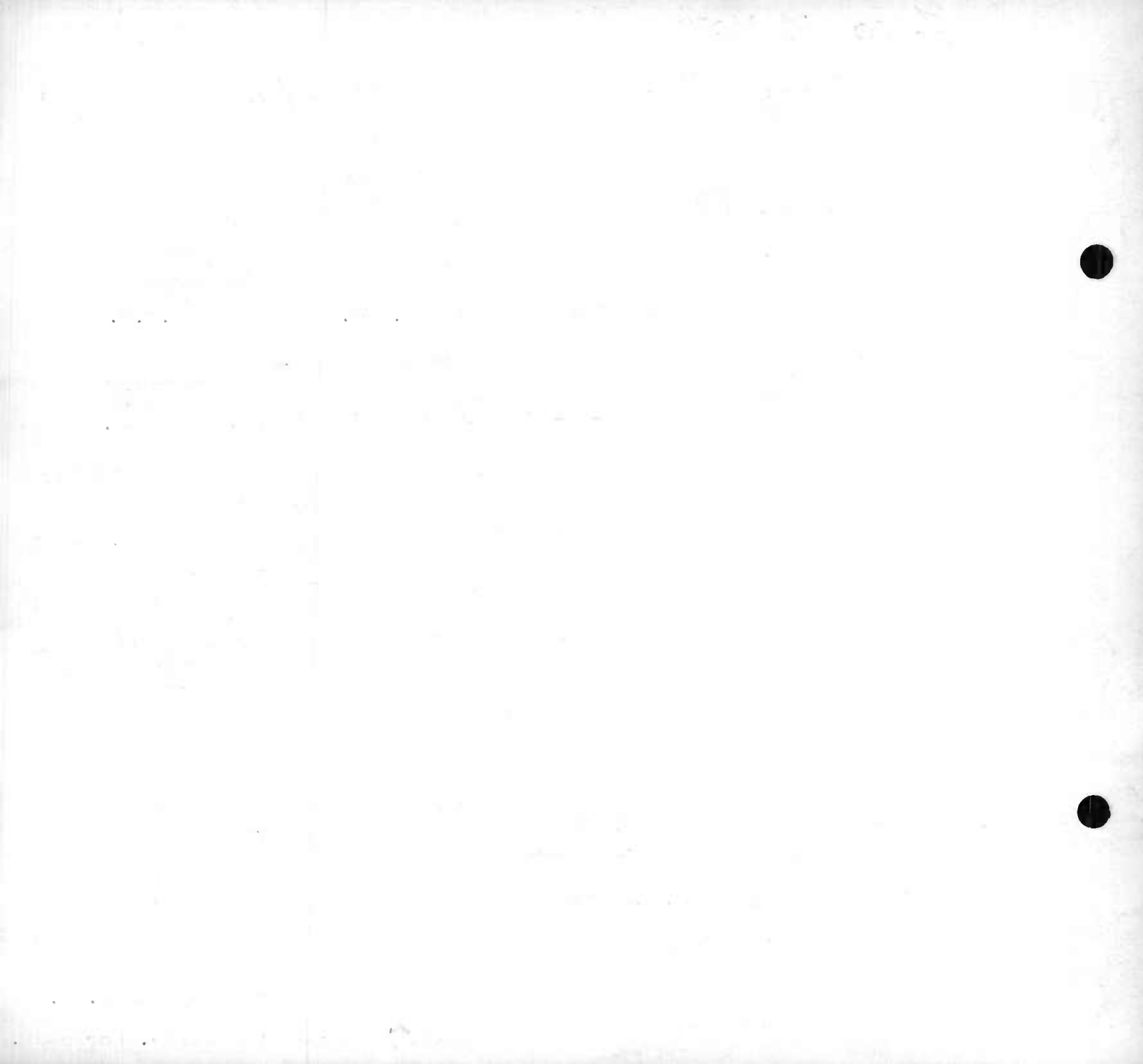
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FUNERAL DIRECTOR: IMPORTANT

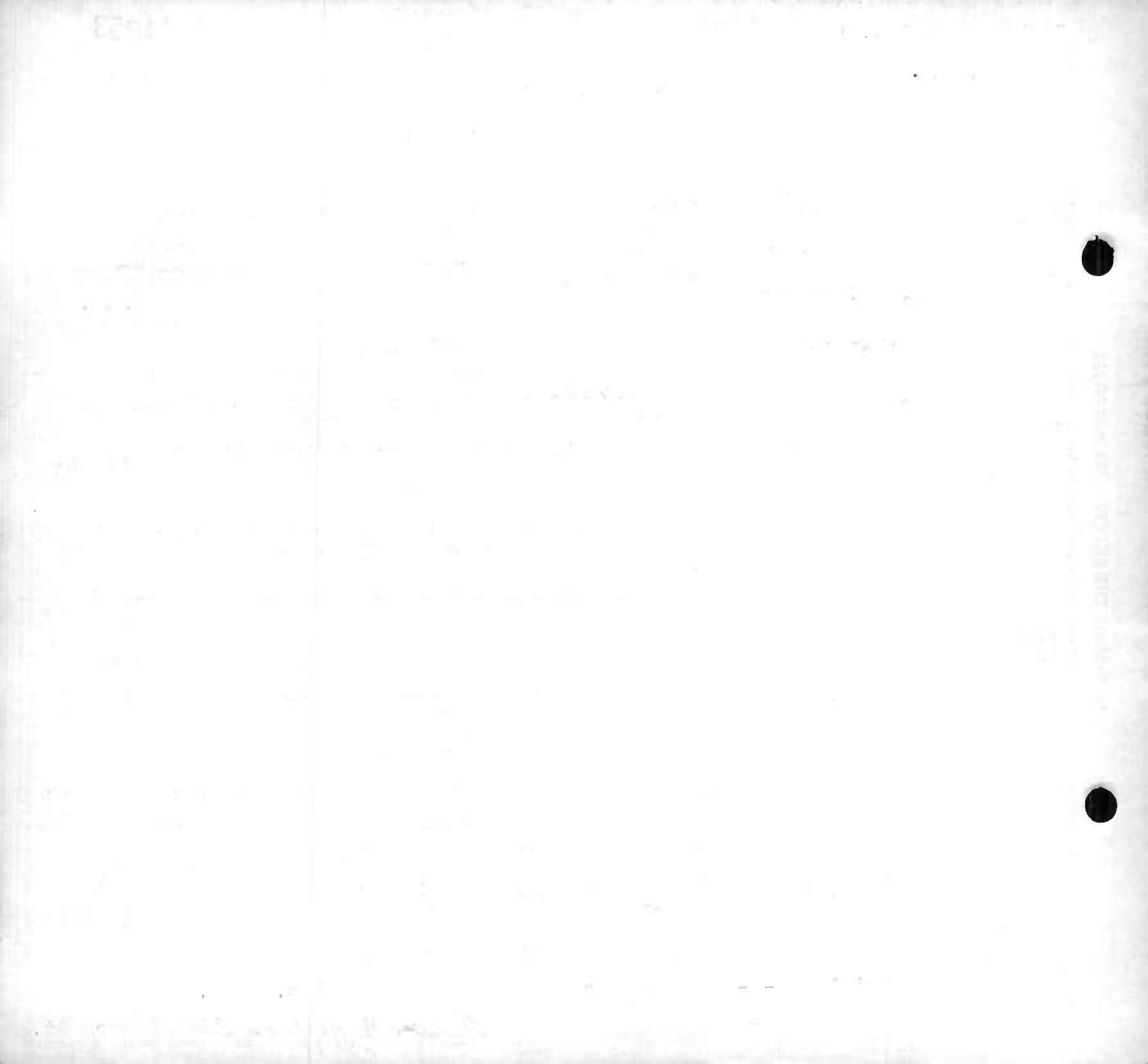
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-000 71 11252		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11252	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Fahey, Carroll</u>		2. DATE AND HOUR OF DEATH <u>12/3/71</u> <u>2:45 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2301</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>The Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1211 Hanover Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/6/04</u>	9. AGE (In years last birthday) <u>67</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Disability</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Francis Fahey</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Burns</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-20-0547</u>		17. INFORMANT <u>Francis Fahey 1211 Hanover St.</u>	
18. <u>162-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Progressive Cardiovascular insufficiency</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Multiple Cardiorespiratory Arrests</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>48 hrs</u>	
		(C) <u>18 days postresection Ca of lung</u>		<u>18 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Post Operative Pneumonia</u>		<u>11 days</u>	
19A. DATE OF OPERATION <u>11/15/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of lung</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>11/4</u> 19 <u>71</u> to <u>12/3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/3</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David Bowman, M.D.</u>		23B. DATE SIGNED <u>12/3/71</u>		23C. PHYSICIAN'S NAME (Type) <u>D David Bowman, M.D.</u>	
23D. ADDRESS <u>Johns Hopkins Hospital, Md</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/6/71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Ritchie Highway Balto. Md.</u>		25A. DATE REC'D. BY HEALTH DEPT. <u>DEC 6 1971</u>	
25B. NAME OF REGISTRAR <u>Blair, Jr., M.D.</u>		25C. FUNERAL DIRECTOR <u>KRAUSE FUNERAL HOME 1216 S. Charles St.</u>		25D. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11253	
BIRTH NO. H-250 71 11253		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HASENEI, HENRIETTA N.		2. DATE AND HOUR OF DEATH 12-3-71 19:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals		A. STATE Maryland	
ADDRESS OR LOCATION 4940 Eastern Avenue		B. COUNTY 2611	
Baltimore, Maryland 21224		C. CITY OR TOWN Baltimore	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1002 South East Avenue 21224	
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaning		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 79
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Sinclair		14. MOTHER'S MAIDEN NAME Rose Jubb	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-20-2667A	
17. INFORMANT 4940 Eastern Avenue		ADDRESS BCH: Records Baltimore, Maryland 21224	
18. 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) THROMBOSIS OF DISTAL AORTA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
(B) _____		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-23 19 71 to 12-3 19 71 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Chu-shin Chiu M.D.		23B. DATE SIGNED 12-3-71	
23C. PHYSICIAN'S NAME (Type) CHU-SHIN CHIU M.D.		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71	
24C. NAME OF CEMETERY OR CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Thelma A. Hoffman		ADDRESS 3218 Hudson St.	



71 11254
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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11254

BIRTH NO.

REG. NO.

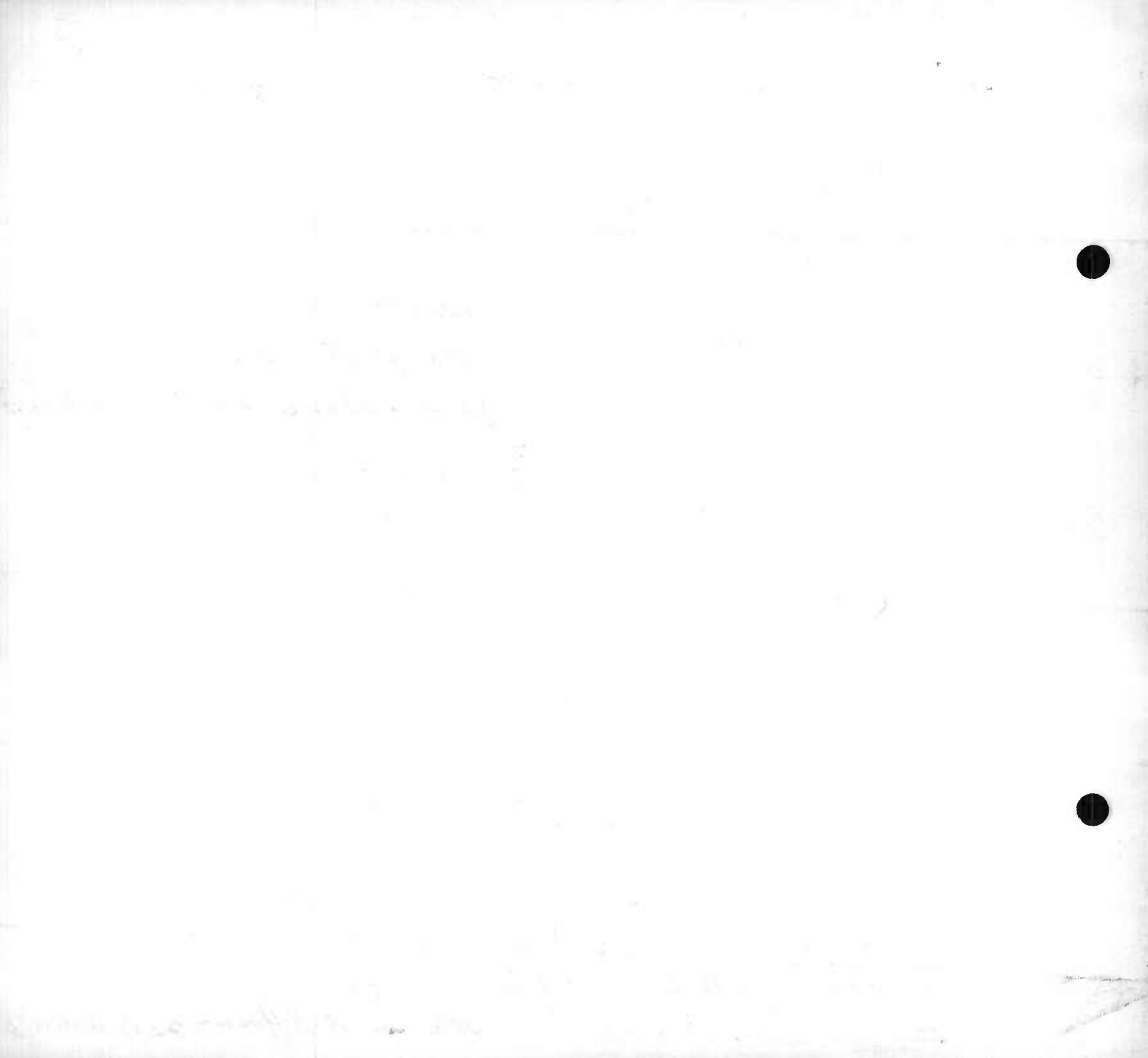
1. NAME OF DECEASED (Type or Print) HOWARD ADAMS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 3, 1971	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year December 3, 1971 5:03 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2607	
9. DATE OF BIRTH May 14, 1898		10. AGE (In years last birthday) 73	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		14B. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army		17. SOCIAL SECURITY NO. 220-05-2755A	
13. FATHER'S NAME Henry Adams		15. MOTHER'S MAIDEN NAME Jennie C. Elliott	
18. INFORMANT Mrs. Rita Post		ADDRESS 501 S. Lehigh St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) Charles S. Springate, M.D.		DATE SIGNED December 3, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71	
24C. NAME OF CEMETERY or CREMATORY Green Mount Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Thelma A. Hoffman		ADDRESS 3218 Hudson St.	

401 *S. Lehigh* *St*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

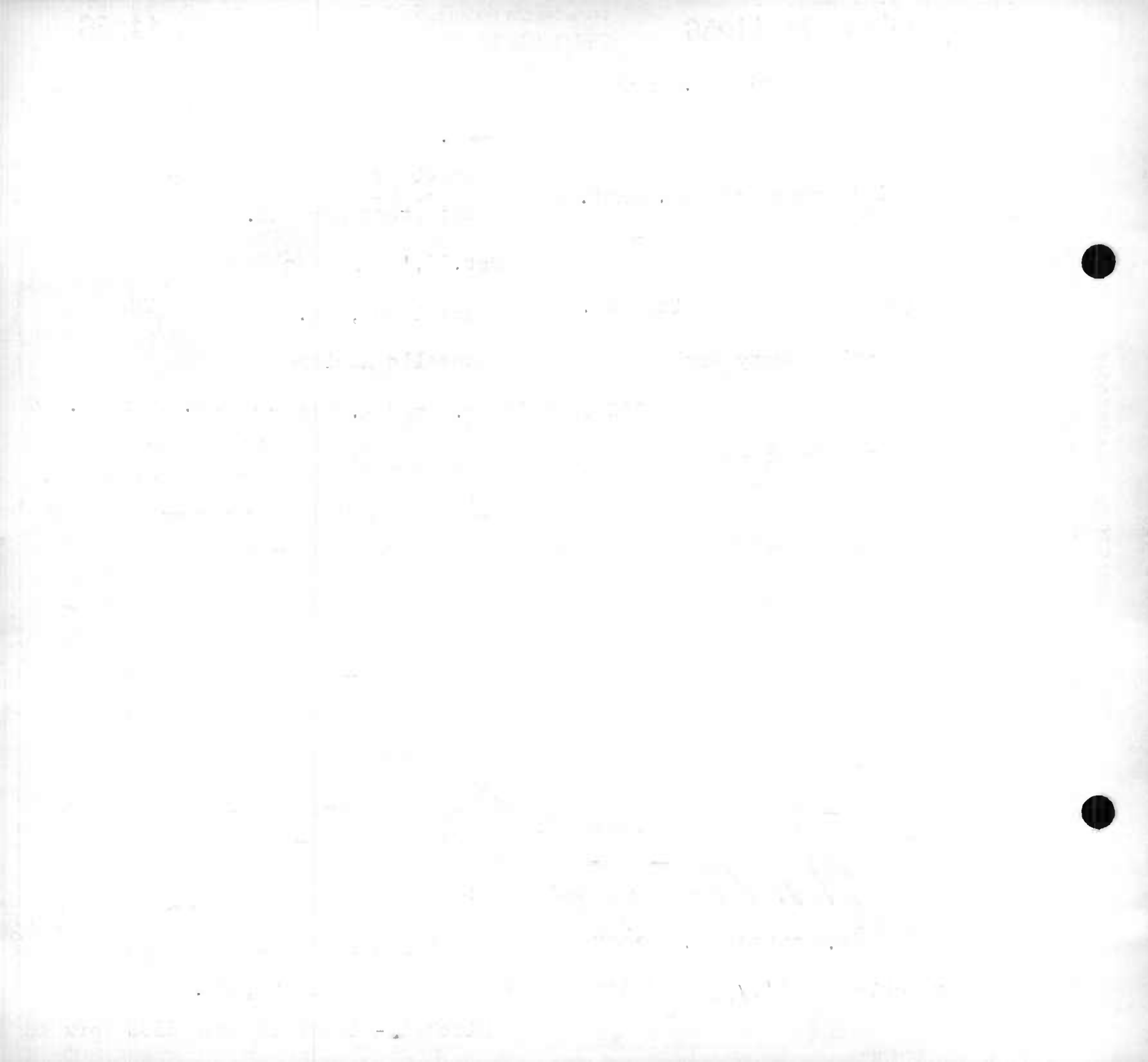
<div style="display: flex; justify-content: space-between;"> D-525 71 11255 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11255	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) MRS. LILLIAN T. DENKINS		2. DATE AND HOUR OF DEATH December 2, 1971 11:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Montebello State Hospital 2201 Argonne Drive Baltimore, Md. 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 202 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 241 South Broadway 21231			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-09-1909	9. AGE (in years lost birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME John B. Weber		14. MOTHER'S MAIDEN NAME Margaret Braun			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Jose Denkins ADDRESS 241 S. Broadway	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Carcinoma of cervix with extensive metastases DUE TO, OR AS A CONSEQUENCE OF: (B) tastases DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from November 24 1971 to Dec. 2 1971 that (I) (we) last saw the deceased alive on Dec. 2 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Corazon M. Cuevas M.D.		23B. DATE SIGNED 12-3-71 Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type) CORAZON M. CUEVAS M.D.		23D. ADDRESS Montebello State Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-6-71	24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Thelma A. Hoffman ADDRESS 3218 Hudson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

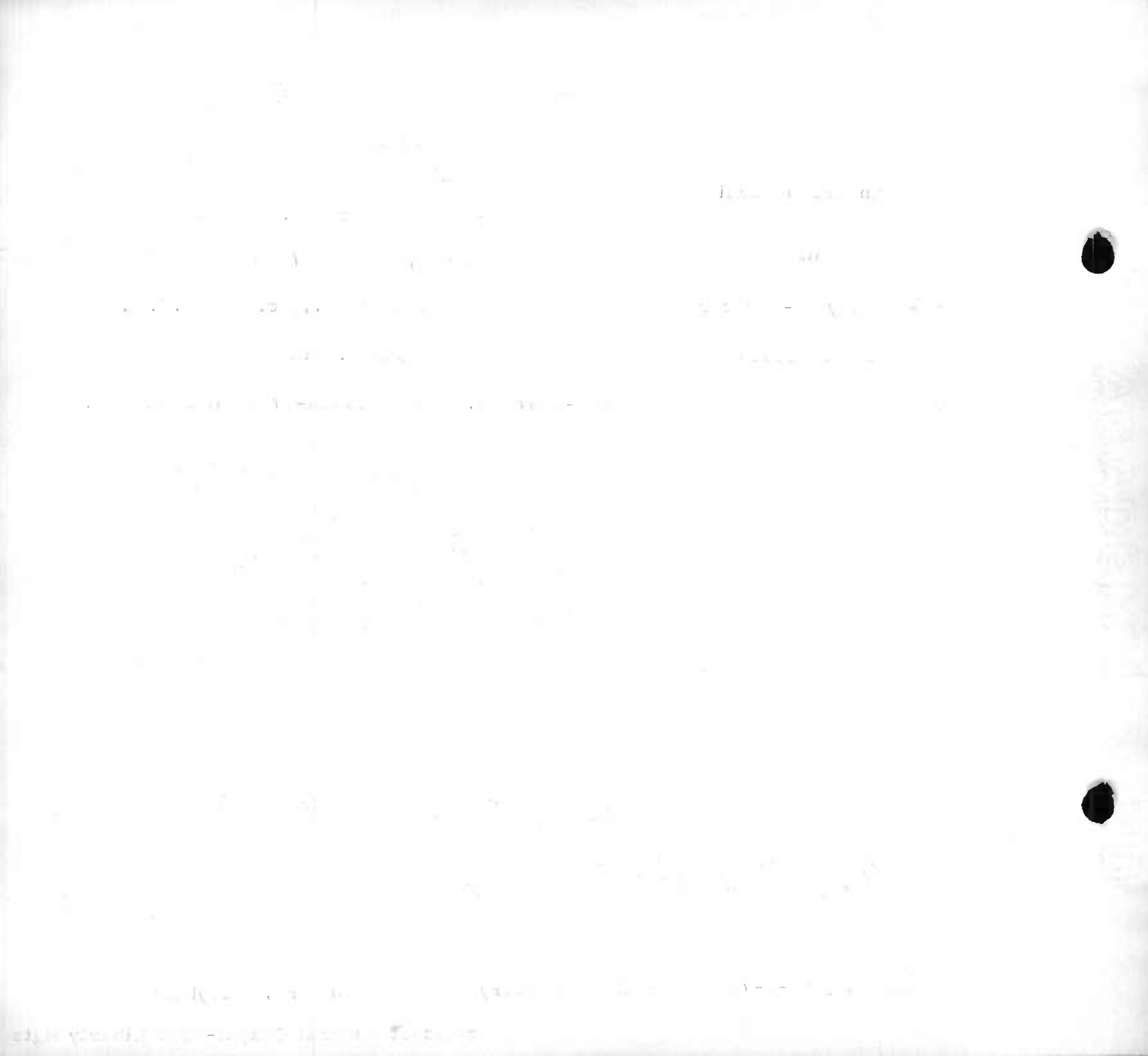
B-200 71 11256		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11256	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charles H. Buck		Dec 2 '71 8:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Md.		
00 105 Cross Keys Rd. Apt. 4			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 105 Cross Keys Rd.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, '89	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY Title Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Henry Buck		14. MOTHER'S MAIDEN NAME Rosella Robinson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212 09 2556		17. INFORMANT Mr. Fred R. Buck 108 St. PAUL St. #02	
18. 431.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Thrombosis Myocardial Degeneration Generalized Arterial Sclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Hrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 1965 to Dec 2 1971 that (I) (we) last saw the deceased alive on Dec 2 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. H. Woody M.D.				23B. DATE SIGNED 12-3-71	
23C. PHYSICIAN'S NAME (Type) DR. WILLIAM H. WOODY				23D. ADDRESS 3105 72 Chas St Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) x Burial		24B. DATE 12/4/71		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Faby, M.D.		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home	
				ADDRESS 6500 York Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11257	
H-250 71 11257					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) C Roy Hesson			2. DATE AND HOUR OF DEATH 12-3-71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Anderson Nursing Home			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY 2854		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4615 Pen Lucy Rd. # 21229		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1884		9. AGE (in years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed - Grocer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.	
13. FATHER'S NAME James Hesson			14. MOTHER'S MAIDEN NAME Leah A. Hill		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-32-3467		17. INFORMANT H. Gwinn Hesson-9726 Hillsmere Rd.
18. 437.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Information Page			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arteriosclerosis			(B) Marked Cerebral Changes		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cerebral Deterioration					
19A. DATE OF OPERATION 11-3-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 1970 to Dec 4 19 71 that (I) (we) last saw the deceased alive on 11-3-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thos J. Afford				23B. DATE SIGNED 11-4-71	
23C. PHYSICIAN'S NAME (Type) Thos J. Afford				23D. ADDRESS Armacost Funeral Chapel-4600 Liberty Hgts	
24A. BURIAL CREMATION Entombment		24B. DATE 12-6-71		24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR John H. H.	
25C. FUNERAL DIRECTOR Armacost Funeral Chapel-4600 Liberty Hgts		25D. ADDRESS			



J-250

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11258

BIRTH NO. *Balto Co. Md.*

REG. NO.

1. NAME OF DECEASED (Type or Print) Lewis Phillip Jackson, Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 1 Year 71 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2511 Perring Manor Road		3. DATE PRONOUNCED DEAD Month 12 Day 1 Year 71 Hour 2:01 p.m.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2737	
9. DATE OF BIRTH Sept. 3, 1971		10. AGE (In years last birthday) 3 mo.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		15. MOTHER'S MAIDEN NAME Christine E Hoskins	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
19. 795X 1		18. INFORMANT Mr Lewis P Jackson	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) yes	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/71	
24C. NAME of CEMETERY or CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc.		25D. ADDRESS Baltimore, Md	

82511

82511



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-160 11259		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11259	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Schaeffer</i>		2. DATE AND HOUR OF DEATH <i>12-1-71 12 50 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Daisy Schaeffer</i> SCHAEFFER		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <i>Century Nursing Home</i> 401 B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> 38		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bookkeeper</i>		8. DATE OF BIRTH <i>1/23/83</i> 9. AGE (In years lost birthday) <i>88</i> If Under 1 Tr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Charles F.J. Schaeffer</i>		14. MOTHER'S MAIDEN NAME <i>Laura F; Unknown</i>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213 54 6056</i>		17. INFORMANT <i>chart</i> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory Arrest</i> (B) <i>Uremia, Chronic Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Carcinoma of Bladder</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 minute</i> <i>3 days</i> <i>unknown</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>11-29-71</i> <i>11-30-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Renal Failure</i> <i>Intestinal obstruction</i>		20A. AUTOPST? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Ten) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frank J. Helma MD</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12/4/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i>	
24D. LOCATION (City, town, or county) (State)		<i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 6 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto., Md.</i>	

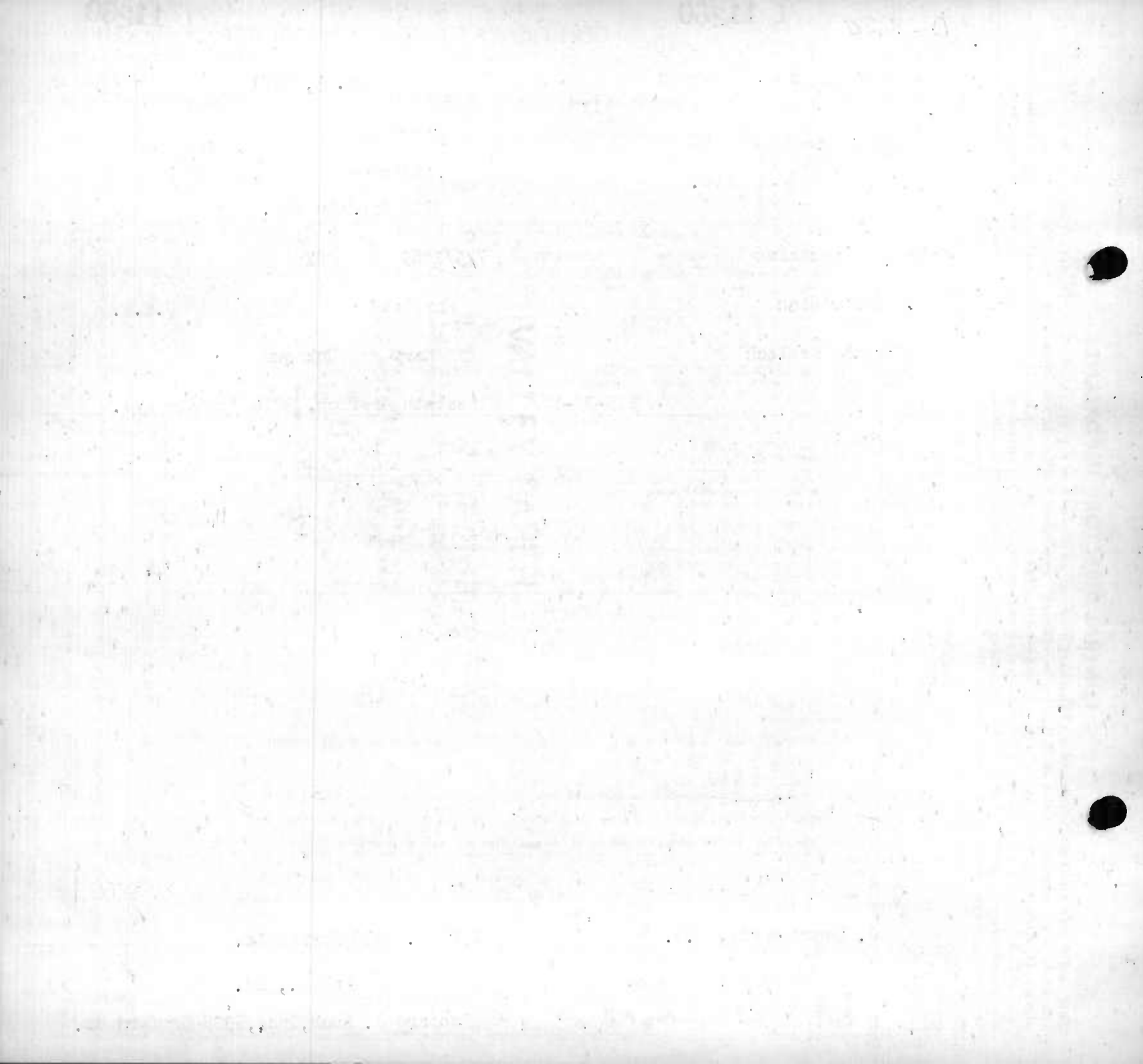
Adm. 4/9/65

102 N. Peach St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11260	
<div style="display: flex; justify-content: space-between;"> D-620 71 11260 </div>				<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>	
1. NAME OF DECEASED (Type or Print) EDWIN JOHN DREISCH				2. DATE AND HOUR OF DEATH Dec. 3, 1971 9:30 a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em; margin-left: 20px;">00</div> 3214 Tyndale Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2731 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3214 Tyndale Ave.	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/1889	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Electrician			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph Dreisch		
14. MOTHER'S MAIDEN NAME Mary Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-03-1027			17. INFORMANT Elizabeth Dreisch, 3214 Tyndale Ave.		
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> 18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Emphysema </div> <div style="width: 35%;"> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C. V. D. (B) Antecedent C. V. D. DUE TO, OR AS A CONSEQUENCE OF: (C) </div> <div style="width: 5%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1951 to Dec 3 19 71 , that (I) (we) last saw the deceased alive on Nov. 22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE J. Henry Haase, M.D.				23B. DATE SIGNED 12/3/71	
23C. PHYSICIAN'S NAME (Type) J. Henry Haase, M.D.				23D. ADDRESS 2926 E. Cold Spring La.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/71		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11261	
M-260 71 11261				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) MATILDA M. MAGRI				2. DATE AND HOUR OF DEATH December 3, 1971 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2748	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5407 Purdue Ave.				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5407 Purdue Ave.					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/1893	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Salvatore Bianco			14. MOTHER'S MAIDEN NAME Marion		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Frank J. Magri ADDRESS 6111 Fairdel Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Bronchopneumonia (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive C.V.D. and Hypothyroidism & marked obesity (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Sclerosis (C) 20 years 2 years		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 19 57 to Dec 3 19 71 , that (I) (we) lost saw the deceased alive on Dec 20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis E. Wice M.D.				23B. DATE SIGNED 12/4/71	
23C. PHYSICIAN'S NAME (Type) L. E. WICE M.D.				23D. ADDRESS 920 St. Paul St., Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/71		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Balto. Md.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balt. Md. 21214	

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

1951-1952

S-326 71 11262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11262

BIRTH NO.

1. NAME OF DECEASED

(Type of birth)

Raymond Steigerwald

2. DATE AND HOUR OF DEATH

December 3, 1971

7:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland

21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

6731 O'Donnell Street

21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

10-11-04

9. AGE (In years last birthday)

67

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Steigerwald

14. MOTHER'S MAIDEN NAME

Mary Funk

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-07-2266

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH: Records Baltimore, Maryland 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, i.e., heart failure, asthma, etc. It means the disease, injury or complication which caused death)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

Sepsis

bronchopneumonia

Inter trochanteric femoral nail

Perforated duodenal ulcer

11 d

11 d

15 d

4 d

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

11/29/71

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

perforated duodenal ulcer

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

home

21C. WHERE DID INJURY OCCUR?

6731 O'Donnell St.

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX)

11 18 71 PM

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

pt lost balance

22. I certify that (I) (this hospital) attended the deceased from ~~11/18~~ 11/18 to 12/1 3 19 71 that (I) (we) last saw the deceased alive on 12/1 3 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Ostrowitz MD

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12/3/71

23C. PHYSICIAN'S NAME (Type)

Arthur Ostrowitz MD

DEGREE

23D. ADDRESS

Baltimore City Hospitals 4940 Eastern Avenue

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-7-71.

24C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

24D. LOCATION (City, town, or county)

Ritchie Highway, A.A.CO., Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1971 Robert E. Taylor, MD

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Charles J. Giller 901 S. Conkling St. Balto., 21224, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 11263	
CERTIFICATE OF DEATH				REG. NO. 71 11263	
BIRTH NO. <u>5-13 71 11263</u>		1. NAME OF DECEASED (Type or Print) <u>HELENA SVOBODA</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>12-03-71</u> <u>04:00 P.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL - BALTO., MD.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7035 E. BALTIMORE ST.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08-25-12</u>	9. AGE (In years last birthday) <u>59</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
13. FATHER'S NAME <u>JOSEPH NOVAK</u>		14. MOTHER'S MAIDEN NAME <u>MARY FLOROVSKY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>AGNES B. WHITTINGTON</u> ADDRESS <u>6800 BROMPTON RD. BALTO. 21207, MD.</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CANCER OF LUNG</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CANCER OF LUNG</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-03</u> 19 <u>71</u> to <u>12-03</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>12-03</u> 19 <u>71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gustavo R. Roca</u> MD		23B. DATE SIGNED <u>12 03 71</u>		23C. PHYSICIAN'S NAME (Type) <u>GUSTAVO R. ROCA</u> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-7-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEM.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Charles S. Feiler</u> ADDRESS <u>6224 EASTERN AVE. BALTO., 21224, MD.</u>	

K-260 71 11264

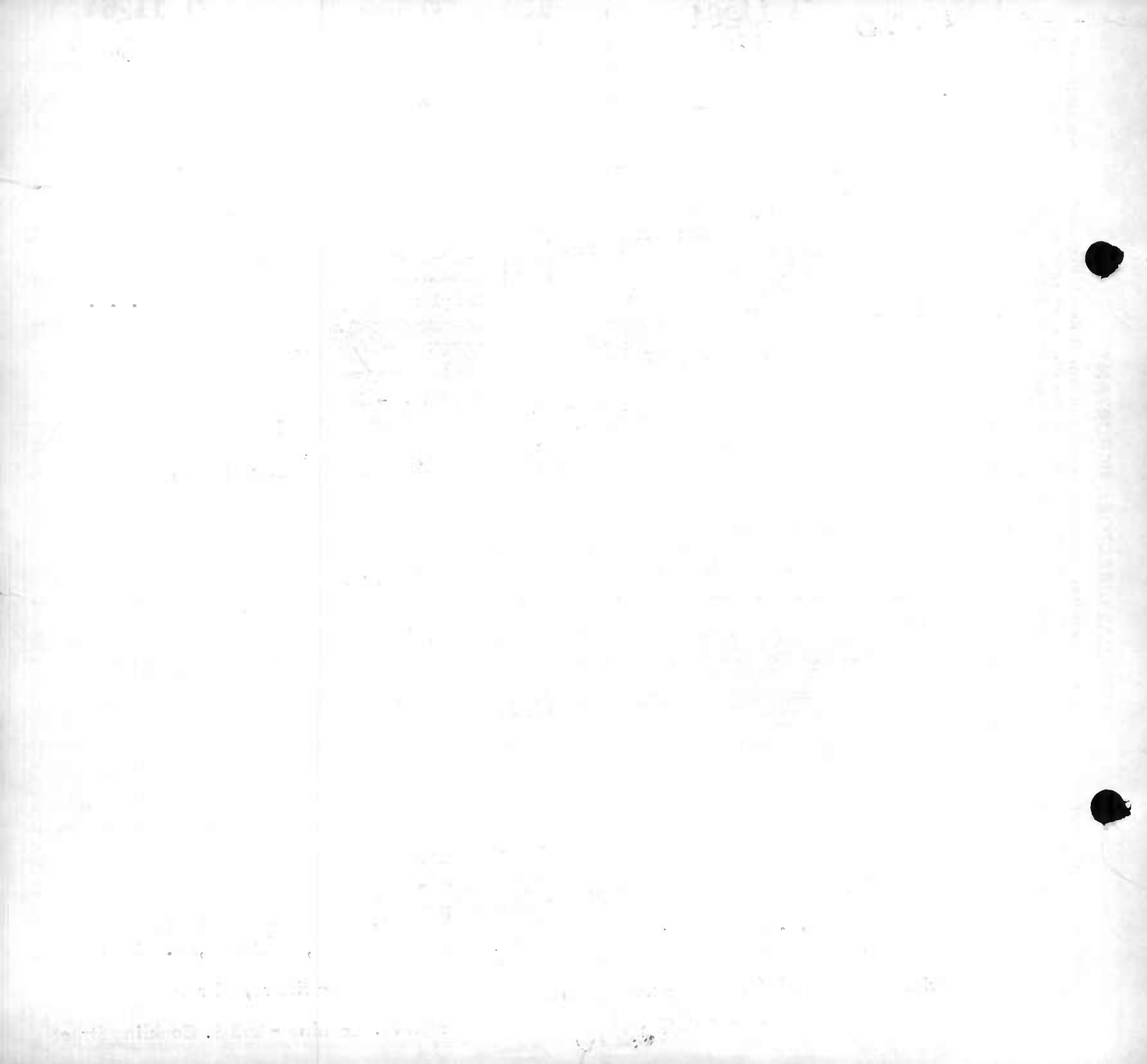
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

71 11264
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MELVIN KEYSER (Kyser)		2. DATE AND HOUR OF DEATH 12-3-71 940 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2610		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 308 South Bouldin Street 21224					
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-15-1920	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Thomas Keyser		
14. MOTHER'S MAIDEN NAME Lillian Grauling			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 218-03-9602			17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224		
18. 347.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiac Arrhythmia, Cardiac Asystole (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypoxia Severe Brain Damage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min ? 3-5 min ~40 hrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypokalemia, Gastritis, Chronic Alcoholism					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-2-71 to 12-3-71 that (I) (we) last saw the deceased alive on 12-3- 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. L. Ramseur Jr. MD			23B. DATE SIGNED 12-3-71 950 AM		
23C. PHYSICIAN'S NAME (Type) W. L. Ramseur Jr.			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/71		24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Joseph N. Zannino - 263 S. Conkling Street			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11265	
A-260 71 11265		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) Azzari, Louise (Luia)		2. DATE AND HOUR OF DEATH 12/5/71 2:30 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2608	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3708 Gough St.			
5. SEX Female	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/81 9. AGE (in years last birthday) 90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Bernardo Fillipponi		14. MOTHER'S MAIDEN NAME Filomena Purantozzi	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ida Manzo		ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory Arrest 15 min (B) Consecutive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: 52 days (C) Myocardial Infarction 32 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 24 19 71 to Dec 5 19 71 that (I) (we) last saw the deceased alive on Dec 5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Eduardo S. Remo M.D.		23B. DATE SIGNED 12/5/71	
23C. PHYSICIAN'S NAME (Type) Eduardo S. Remo M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/71	
24C. NAME of CEMETERY or CREMATORY Sacred Heart		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Talley	
25C. FUNERAL DIRECTOR Joseph N. Zannino		ADDRESS 263 S. Conkling Street	

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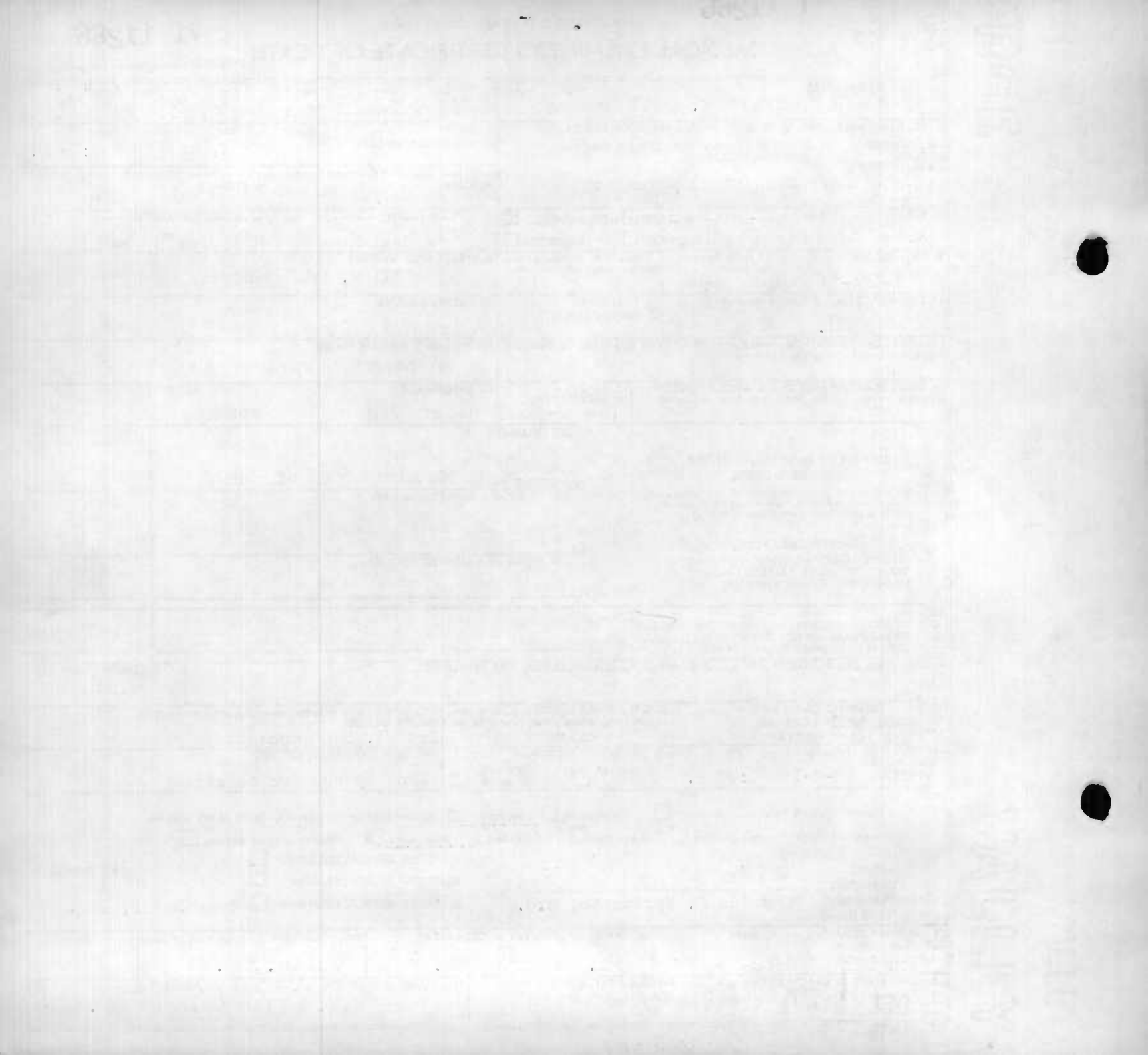
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

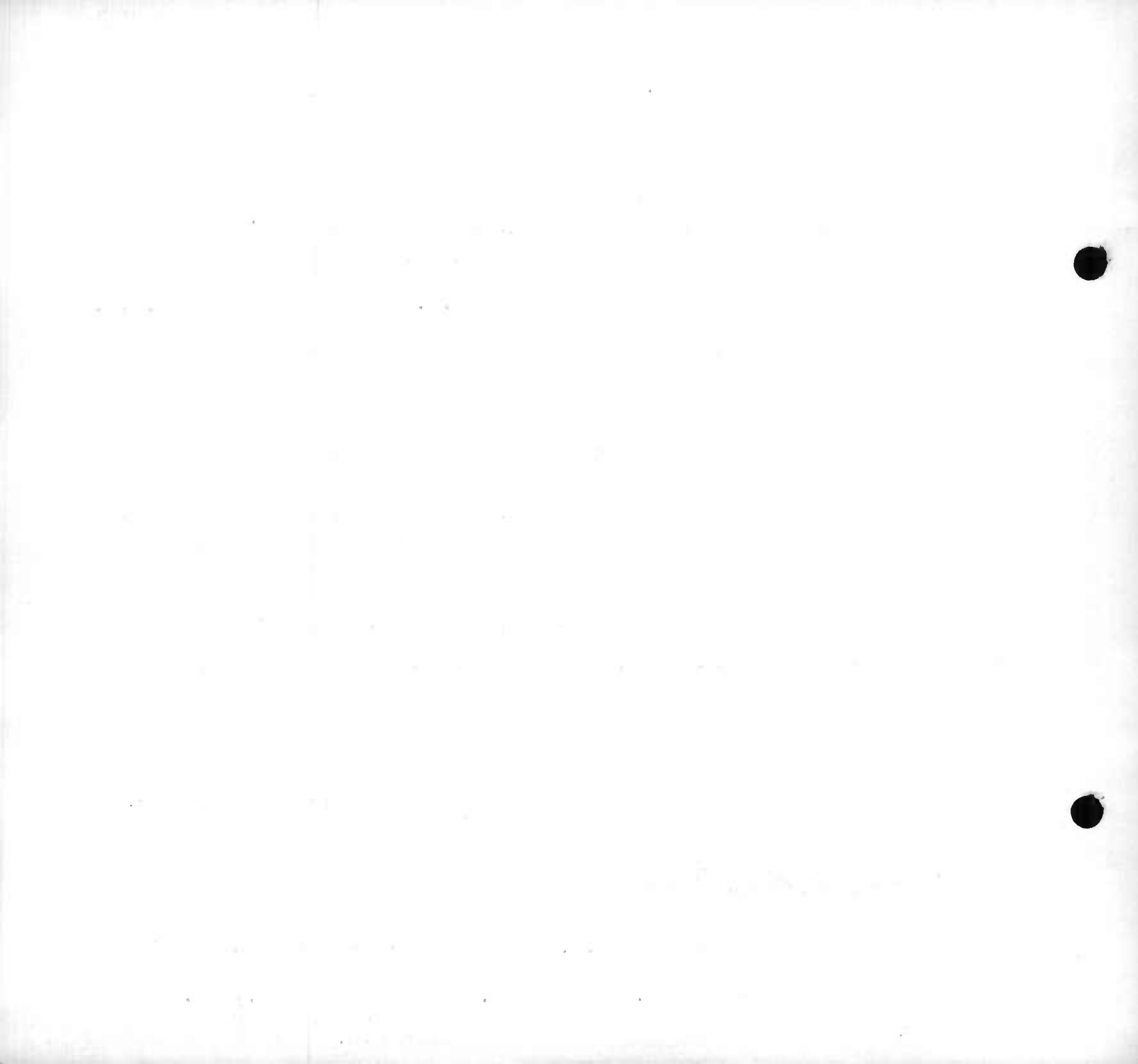
1. NAME OF DECEASED (Type or Print) JEROME G. STEWART Jones		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 2, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3400 Auchentoroly Terrace		3. DATE PRONOUNCED DEAD Month Day Year Hour December 2, 1971 4:15 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1606	
9. DATE OF BIRTH 11-27-52		10. AGE (In years last birthday) 19	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emmanuel Pinnick		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Dorothy Stewart		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 214-58-5627		18. INFORMANT Helen Jones ADDRESS same	
19. E 965 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) stairs		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3rd fl. 3400 Auchentoroly Terrace 1304	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-2-71 4:02 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot by unknown assailant		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 3, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

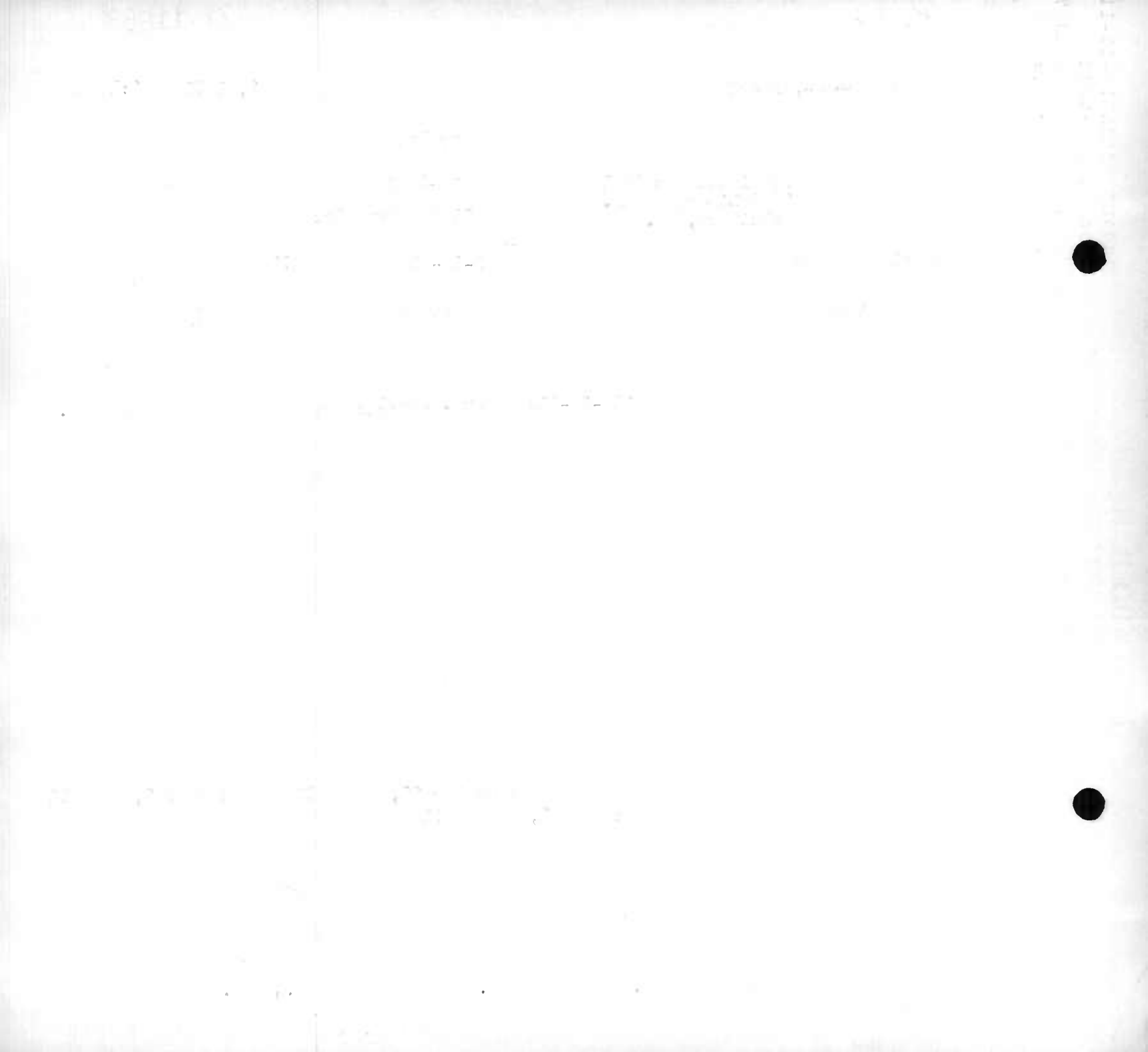
BALTIMORE CITY HEALTH DEPARTMENT				71 11267	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Luther W. Starks		12-4-71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3038 Virginia Avenue			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY 2572		
5. SEX Male		6. RACE Negroid		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-29-15		9. AGE (In years last birthday) 56		10. CITIZEN OF WHAT COUNTRY U.S.A.	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME James Starks	
14. MOTHER'S MAIDEN NAME Betty Branch		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213072845	
17. INFORMANT Florence Starks		ADDRESS same		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CARDIAC DECOMPENSATION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE ARTERIO-SCLEROTIC CARDIOVASC. DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 6 + yrs. 60 + yrs.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus - uncontrolled.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1969 to 12-4-1971 that (I) (we) last saw the deceased alive on 11-30-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Deckelbaum				23B. DATE SIGNED 12-6-71	
23C. PHYSICIAN'S NAME (Type) Joseph Deckelbaum, M.D.				23D. ADDRESS 3502 W. Rogers Ave. 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto., Md.		24E. FUNERAL DIRECTOR V. Bailey		24F. ADDRESS 1348 Calhoun Street	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Kelson F.H.		25C. ADDRESS 1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

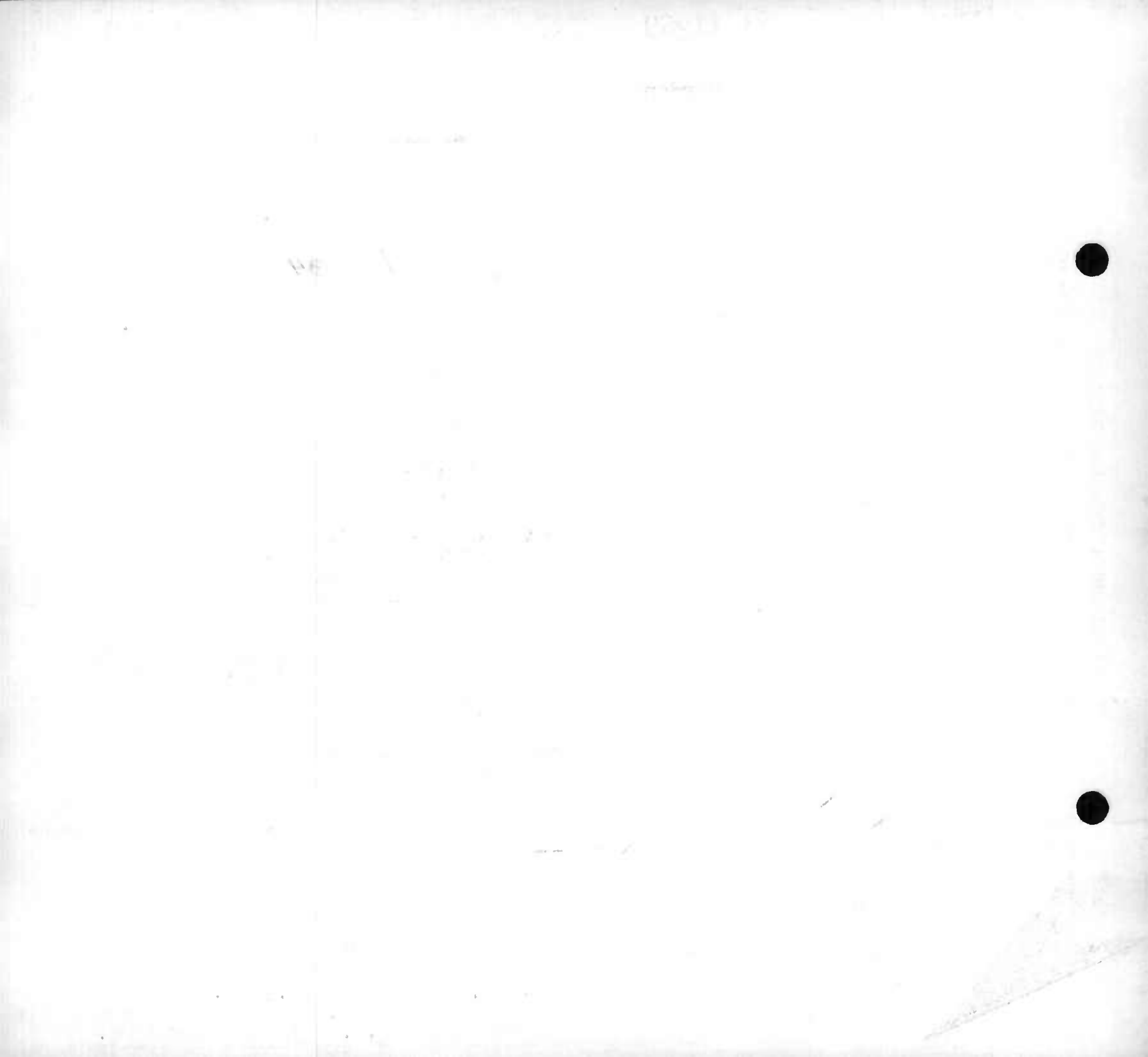
BIRTH NO. 71 11268		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11268	
1. NAME OF DECEASED (Type or Print) Pearl Rhoades			2. DATE AND HOUR OF DEATH December 2, 1971 2:10 A		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital 2600 Liberty Hgts. Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1403 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2104 Eutaw Place		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-99	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME James Rhoades			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 219-26-1150		
17. INFORMANT Mrs. Alverta Fowler			ADDRESS 2501 Riggs Ave.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 466X1			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF:		
			(B) Toxemia DUE TO, OR AS A CONSEQUENCE OF:		
			(C) Purulent Infectious Bronchitis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Aspiration Pneumonia					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 22, 1971 to December 2, 1971 that (I) (we) last saw the deceased alive on December 2, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Felix C. Pool, M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971			
25B. NAME OF REGISTRAR Robert E. Sabin, M.D.		25C. FUNERAL DIRECTOR V. Bailey			
25D. ADDRESS Kelson F.H. 1348 Calhoun Street					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-163 71 11269		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11269	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES Neverdon		2. DATE AND HOUR OF DEATH DECEMBER 5 1971 8:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 901		C. CITY OR TOWN Baltimore, Md.	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-37	9. AGE (In years last birthday) 34	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY ADVANCE Storage Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Charles Howard Neverdon		14. MOTHER'S MAIDEN NAME HATTIE O. Neverdon		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-32-8417		17. INFORMANT Francis Neverdon ADDRESS same	
18. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Hypovolemic Shock DUE TO, OR AS A CONSEQUENCE OF: (B) Massive Acute GI bleeding DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Alcoholism, Dehydration		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that W (this hospital) attended the deceased from DEC 3 1971 to DEC 5 1971 that (I) (No) lost saw the deceased alive on DEC 5 1971 and that (in my) (No) opinion death occurred on the date and hour and from the causes stated above. (I) (No) (did) (did not) view the body after death.					
23A. SIGNATURE Rayman I. Alley MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/5/71	
23C. PHYSICIAN'S NAME (Type) Rayman I. Alley MD		23D. ADDRESS PROVIDENT HOSPITAL INC			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-8-71	24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Bailey MD		25C. FUNERAL DIRECTOR Kelson F.H. ADDRESS 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-350 71 11270		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11270	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Eliza A. Sutton		2. DATE AND HOUR OF DEATH Dec. 1, 1971 1:45 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1509		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 00 2213 Mt. Holly Street		E. STREET AND NUMBER 2213 Mt. Holly St.			
5. SEX F	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-00	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eliza Curry		14. MOTHER'S MAIDEN NAME Deliah Carter	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Baldwin Alfred Sutton ADDRESS 4715 Midwood Ave.	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASHD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 9/28 19 71 to 11/28 19 71 that (I) (we) last saw the deceased alive on 11/28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Theodore C. Wilson</i>		23B. DATE SIGNED 12/2/71		23C. PHYSICIAN'S NAME (Type) F.C. Wilson	
23D. ADDRESS MD 1709 Gwynns Falls		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-71	
24C. NAME OF CEMETERY OR CREMATORY Church Cem.		24D. LOCATION (City, town, or county) (State) Northumberland Co., Va.		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971	
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR V. Bailey		25D. ADDRESS Kelson F.H. 1348 Calhoun Street	

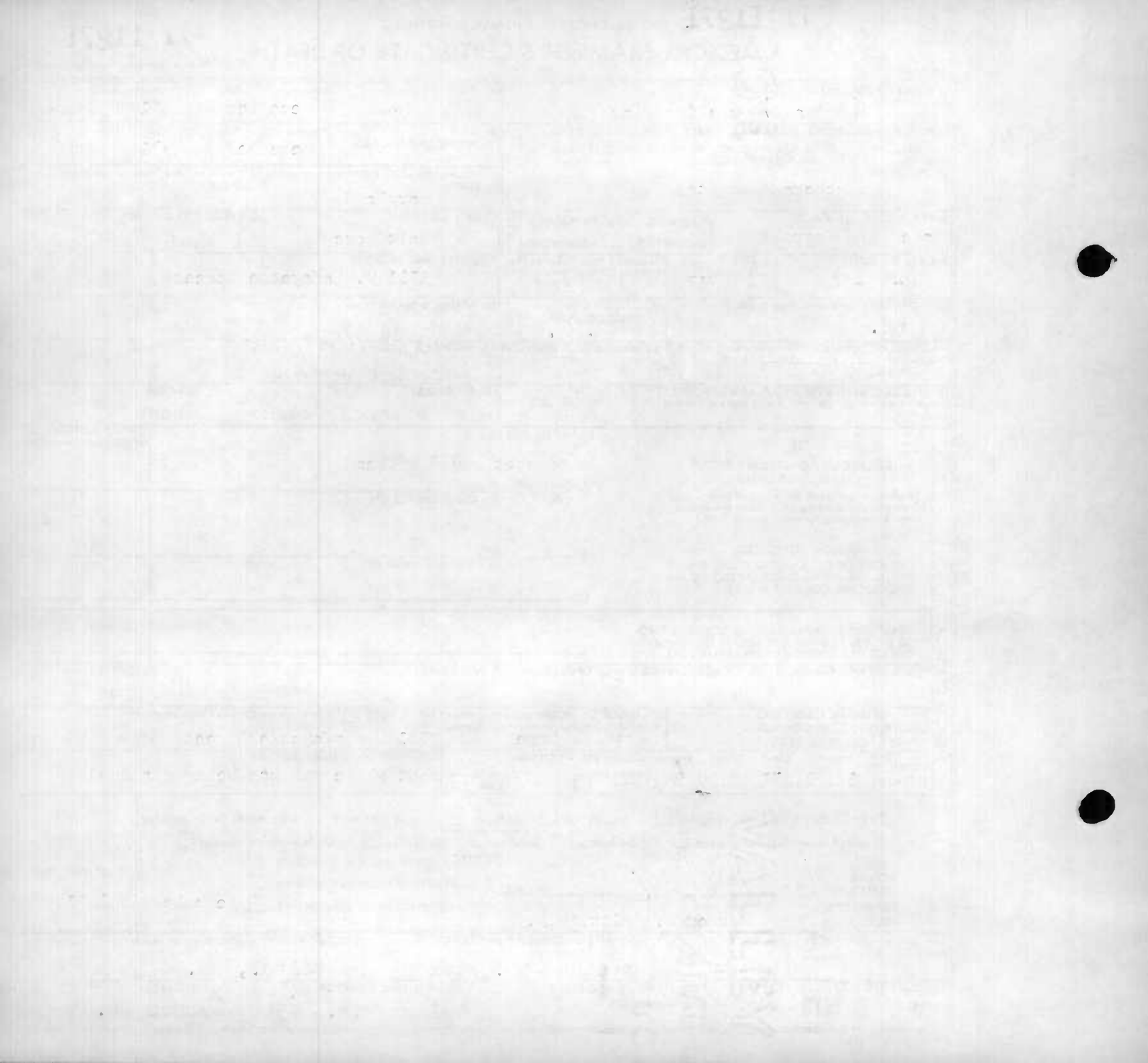


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Reginald Cornelius Clark		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 4, 1971		Hour 8:15 AM
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year December 4, 1971		Hour 8:15 AM
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1606		6. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH 8-11-54	10. AGE (In years last birthday) 17	11. BIRTHPLACE (State or foreign country) Md.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Clark		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		15. MOTHER'S MAIDEN NAME Mary Lee Johnson		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT Mary & James Clark
19. E922.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2731 W Lafayette Street 1606
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12, 3, 71 9:00 PM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot while gun was being examined
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 4, 1971 ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		
25B. NAME OF REGISTRAR Robert E. Gentry, M.D.		25C. FUNERAL DIRECTOR Kelson F.H. 1348 Calhoun St.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11272
BIRTH NO. B-346		71 11272		
1. NAME OF DECEASED Willie Mae Butler (Type or Print)		2. DATE AND HOUR OF DEATH 11-30-71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1547		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1600 Edmondson Avenue		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE Negroid		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9-1-16
13. FATHER'S NAME Caleb McDaniel		14. MOTHER'S MAIDEN NAME Elizabeth		9. AGE (in years last birthday) 55
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 130-10-5106		11. BIRTHPLACE (State or foreign country) S.C.
17. INFORMANT Leon Butler husband		ADDRESS same		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute coronary occlusion Sudden ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease 6 years		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 9 1965 to 11-30-71 19 71 that (I) (we) last saw the deceased alive on Sept 3 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE William H. Watts		23B. DATE SIGNED 12-1-71		23C. PHYSICIAN'S NAME (Type) William H. Watts
23D. ADDRESS 515 N. Arlington Av, Balto Md		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 12-4-71		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Bailey, R.D.		25C. FUNERAL DIRECTOR V. Bailey
				ADDRESS Kelson F.H., 1348 N. Calhoun Street

12/10/71 - Correction form from funeral director. *Life*

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71 11273

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11273

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) EARNEST ERNEST GOLD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month December Day 2 Year 1971 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital (DOA) (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month December Day 2 Year 1971 Hour 9:05 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1607	
9. DATE OF BIRTH 10-13-17		10. AGE (In years lost birthday) 54 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) St. Matthews, S. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 250-32-7700		18. INFORMANT Bonnie M. Gold ADDRESS 2808 Belmont St.	
19. E965X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? in front of 2103 Bolten Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-2-71 8:48 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 3, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-71-71	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Gabley, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	

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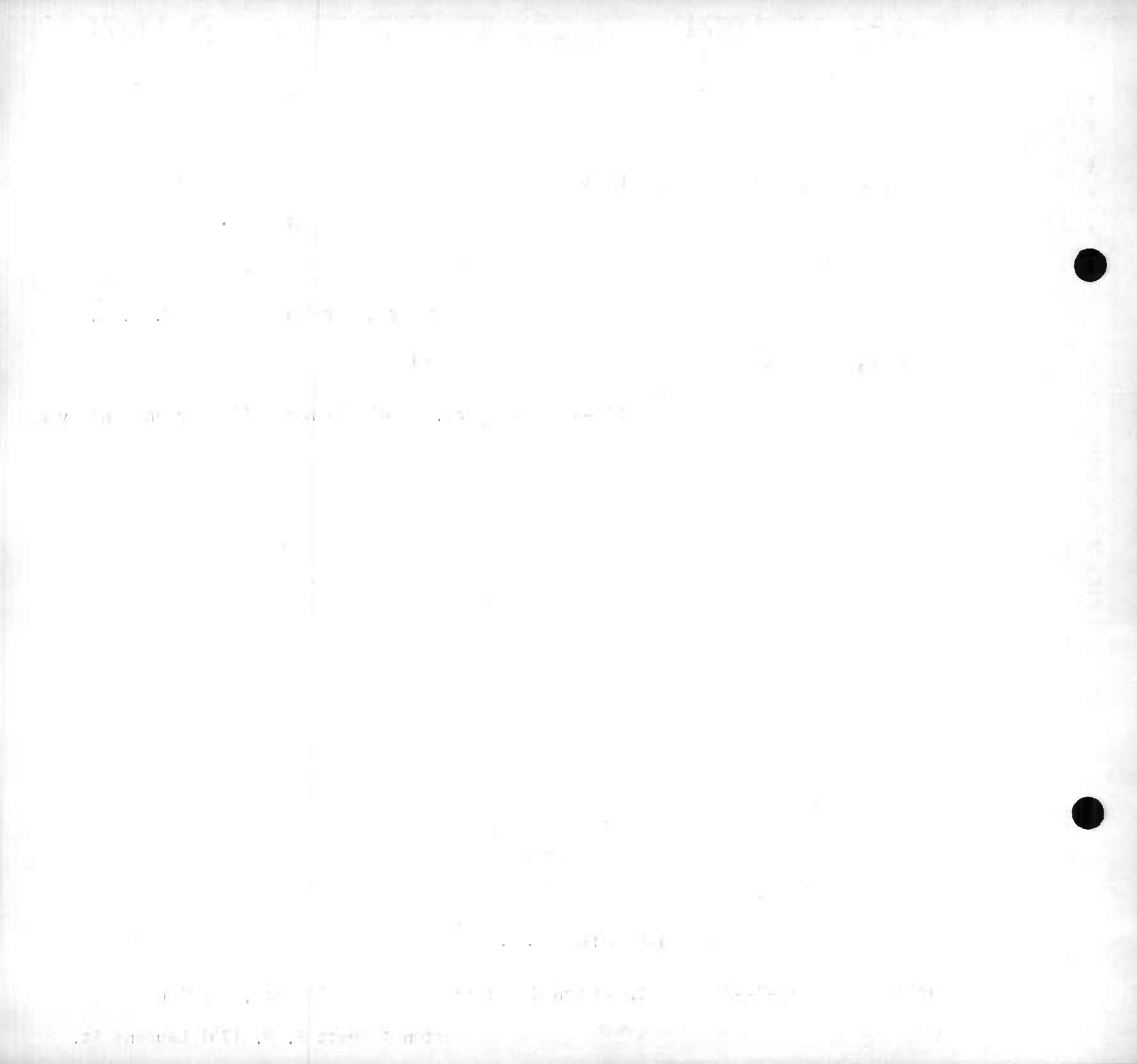
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11274	
BIRTH NO. S-152 71 11274		1. NAME OF DECEASED (Type or Print) Mary C. Spense		2. DATE AND HOUR OF DEATH 12/2/71 4⁰⁰ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33			A. STATE MARYLAND B. COUNTY 1001		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1105 GREENMOUNT AVE.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-86	9. AGE (in years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME GRAY, DAVE		14. MOTHER'S MAIDEN NAME KATIE		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216--619542		17. INFORMANT ADDRESS Mrs. Sophie Turner 1105 Greenmount Avenue	
18. 43671 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gram \ominus Septicemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Recurrent Aspiration Pneumonias Multiple old CVA's			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Recurrent Aspiration Pneumonias (C) Multiple old CVA's APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/30 19 71 to 12/2 19 71 that (I) (we) last saw the deceased alive on 12/2 19 71 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Franklin Grim M.D.				23B. DATE SIGNED 12/2/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JAMES FRANKLIN GRIM M.D.		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-7--71		Mt. Auburn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 6 1971		Robert E. Taylor, M.D.		Morton & Dyett F. H. 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-633 71 11275 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 11275 REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>HOBERT MEREDITH</u>			2. DATE AND HOUR OF DEATH <u>12/2/71 12⁴⁶ PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. OF MARYLAND HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1402</u>		
5. SEX <u>M</u>			6. RACE <u>N</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>8/14/01</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		
11. BIRTHPLACE (State or foreign country) <u>ALABAMA, Leighton</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>FRANK MEREDITH</u>			14. MOTHER'S MAIDEN NAME <u>BROWN, Cynthia</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>			16. SOCIAL SECURITY NO. <u>518-074346</u>		
17. INFORMANT <u>CHART-Helen Wright</u>			ADDRESS <u>1701 Place</u>		
18. CAUSE OF DEATH <u>412.4 I</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>ASPIRATION</u> DUE TO, OR AS A CONSEQUENCE OF: <u>RETAINED GASTRIC SECRETIONS</u>		
(B) ASCUD DUE TO, OR AS A CONSEQUENCE OF:			(C) POSSIBLE MESENTERIC THROMBOSIS <u>1 DAY</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/2/71 2 AM</u> 19 <u>71</u> to <u>12/2/71 12 PM</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/2/71</u> 19 <u>71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George H. Brouillet Jr. M.D.</u>				23B. DATE SIGNED <u>12/2/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>GEORGE H. BROUILLET JR. M.D.</u>				23D. ADDRESS <u>U OF MD. HOSPITAL</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-6-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Sabey, R.D.</u>		25C. FUNERAL DIRECTOR <u>Morton Dyett F.H. 1701-1705</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71-11276</u>	
L-200 71 11276				71 11276	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Leak, Mrs. Barbara a</u>			2. DATE AND HOUR OF DEATH <u>11-30-71 9:20 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1605</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>Female</u> 6. RACE <u>B</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3/23/37</u> 9. AGE (in years last birthday) <u>34</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>N.C. High Point</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Harry Warlman</u>			14. MOTHER'S MAIDEN NAME <u>Willie Mae Randle</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>217-34-8957</u>		
17. INFORMANT <u>Charles Leak</u>			ADDRESS <u>2642 W. Franklin</u>		
18. <u>571.01</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			<u>Hepatic coma</u>		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<u>Fatty liver</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			<u>Chronic etc.</u>		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>11-30-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White AI <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from <u>11/30</u> 19 <u>71</u> to <u>11/30</u> 19 <u>71</u> that (H) (we) last saw the deceased alive on <u>11/30</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Arvornee Bichairoyarongsonegram M.D.</u>				23B. DATE SIGNED <u>11/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ARVORNEE BICHAIRONARONGSONEGRAM M.D.</u>				23D. ADDRESS <u>BON SECOURS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-6-71</u>		24C. NAME of CEMETERY or CREMATORY <u>St Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore Md</u>		24E. FUNERAL DIRECTOR <u>Morton Dyett F.H. Mortuary</u>		ADDRESS <u>1401-1409 St</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton Dyett F.H. Mortuary</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11277	
<div style="display: flex; justify-content: space-between;"> B-424 71 11277 CERTIFICATE OF DEATH </div>					
BIRTH NO. 1. NAME OF DECEASED (Type or Print) BLACKWELL, LETTITA		2. DATE AND HOUR OF DEATH 12-3-1971 at 1:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 46 LUTHERAN HOSPITAL OF MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND 21215 B. COUNTY 1504			
5. SEX Female 6. RACE N.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-22-1889 9. AGE (In years last birthday) 82 years.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Heathville, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Croston		14. MOTHER'S MAIDEN NAME Helen A. Croston	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Walter Blackwell 1907-N. Monroe	
18. 441.2 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Aneurysm of Abdominal aorta. ANTECEDENT CAUSES Atherosclerosis. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Samrat M.D.		23B. DATE SIGNED 12/3/71		23C. PHYSICIAN'S NAME (Type) J. SAMRAT - M.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12-7-71		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Feltz, M.D.		25C. FUNERAL DIRECTOR Morton Dyett F.H. 1701 - Laurens	

115/71

1907 Monroe St 21217


FUNERAL DIRECTOR: IMPORTANT

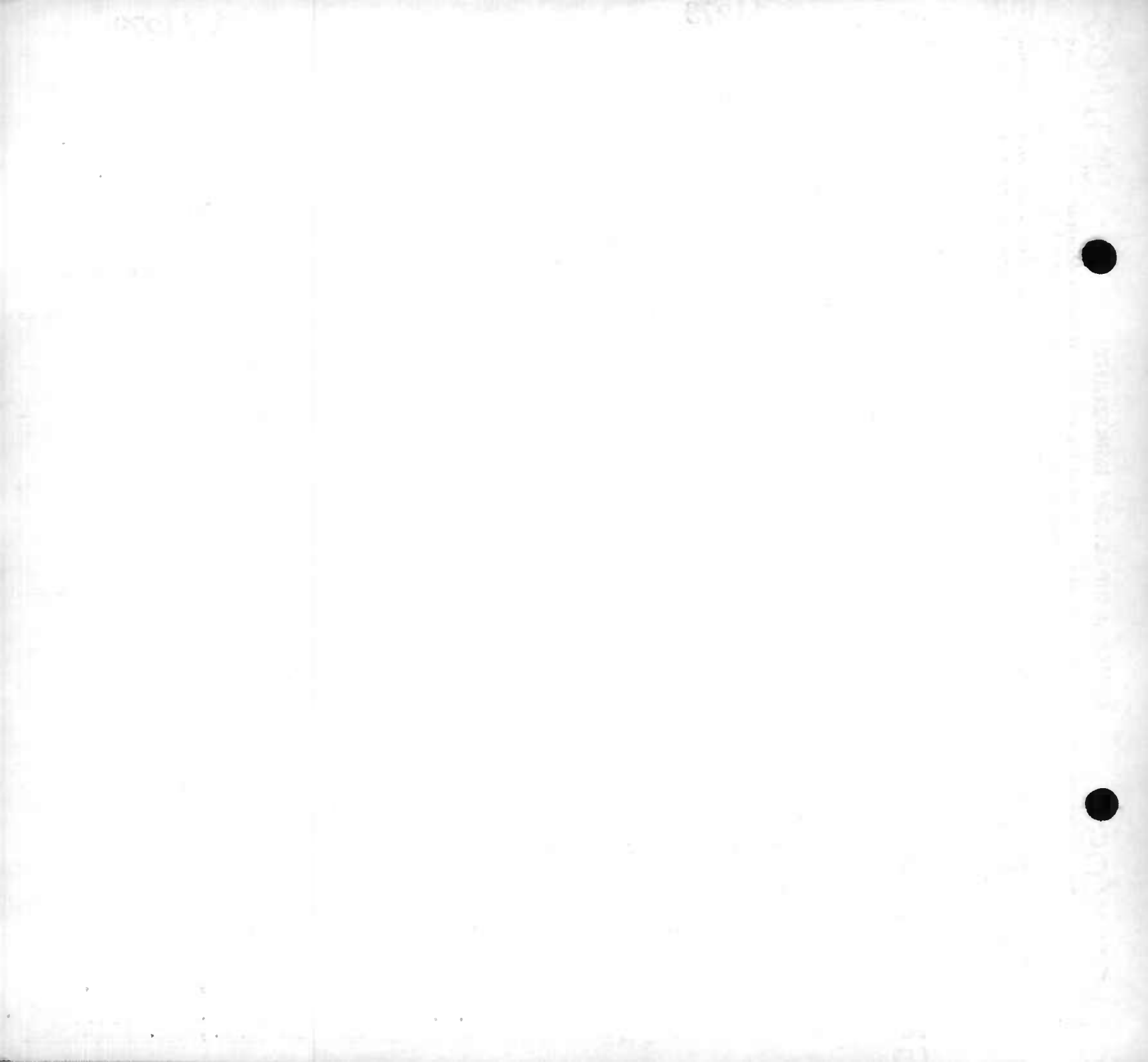
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11278	
M-200 71 11278		BIRTH NO.		71 11278	
1. NAME OF DECEASED (Type or Print) Jesse McCoy		2. DATE AND HOUR OF DEATH December 3, 1971 8:35 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 4/3/08	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary McCoy		9. AGE (in years lost birthday) 63	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 218-05-0708		11. BIRTHPLACE (State or foreign country) Fairburn, Georgia	
17. INFORMANT Harvie McIntyre		ADDRESS 1221-W. North Ave		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Terminal Bacteremia.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sacroiliac infection with thromb.			
		(B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia			
		(C) Bleeding.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/1/71 to 12/3/71 that (I) (we) last saw the deceased alive on 12/3/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Helen Don Anderson				23B. DATE SIGNED 12-3-71	
23C. PHYSICIAN'S NAME (Type) R. LONG M. STUBBINS				23D. ADDRESS 7112 Dorsington Drive Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Morton Dyett F.H.		25D. ADDRESS 1701-1705			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

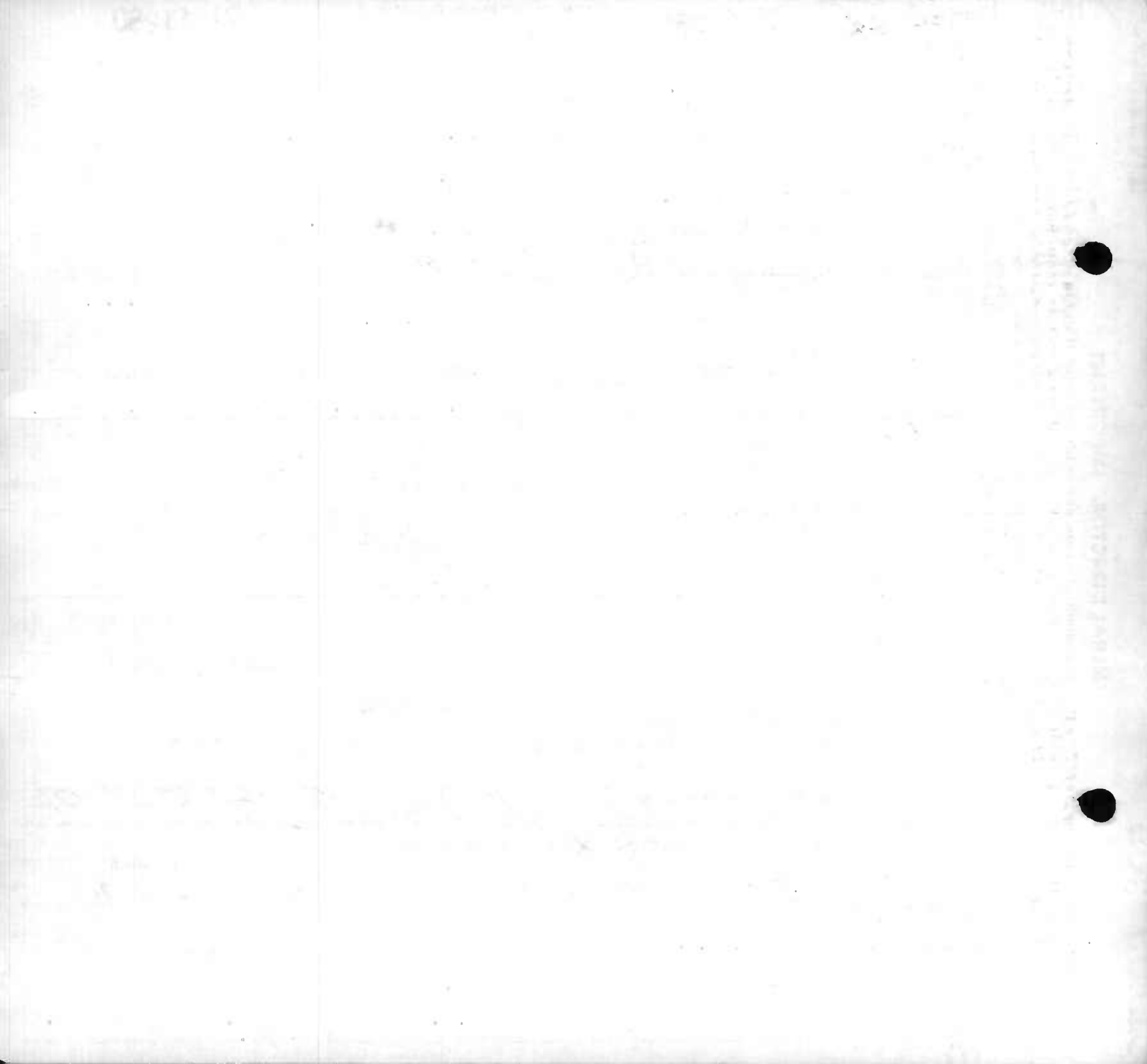
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11279	
CERTIFICATE OF DEATH					
BIRTH NO. D-242 71 11279					
1. NAME OF DECEASED (Type or Print) DOUGLAS VIVIAN T.			2. DATE AND HOUR OF DEATH Dec. 3 1971 7³⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			A. STATE MARYLAND CITY CITY OF BALTO 2714		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4401 ROLAND AVE.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-05-96	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE MGR.		10B. KIND OF BUSINESS OR INDUSTRY PROCTOR-GAMBLE		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME VIVIAN T. DOUGLAS SR.			14. MOTHER'S MAIDEN NAME ANNIE TAYLOR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 216-078609A		17. INFORMANT ADDRESS MRS. MARGARET DOUGLAS (SAME)	
18. 156-71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) HEPATIC FAILURE			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CARCINOMA of biliary tract DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-30-71 19 to 12-3-71 19 that (I) (we) last saw the deceased alive on 12-3-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 12-3-71	
23C. PHYSICIAN'S NAME (Type) JAIRO RAMIREZ				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/6/71		24C. NAME OF CEMETERY or CREMATORY Bethel Baptist Church	
Burial				24D. LOCATION (City, town, or county) (State) Midlothian, Va.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Feltz, Jr.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
				ADDRESS 4905 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11280	
BIRTH NO. <u>H-634</u> <u>71 11280</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Hartley, Sarah G. (Sadie)</u>			2. DATE AND HOUR OF DEATH <u>12/5/71</u> <u>10:30</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital, Inc.</u>			A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <u>219 Gaywood Rd. 21229</u>		
5. SEX <u>Female</u>	6. RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/97</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm. George Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Rebecca Ennis</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-36-9113</u>		17. INFORMANT <u>Mr. James W. Hartley</u>	
18. CAUSE OF DEATH		19. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Congestive Heart Failure</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>CVA</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>NO</u> (this hospital) attended the deceased from <u>11-7</u> 19 <u>71</u> to <u>12-5</u> 19 <u>71</u> that <u>NO</u> (we) last saw the deceased alive on <u>12-5</u> 19 <u>71</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>Yes</u> (did not) view the body after death.					
23A. SIGNATURE <u>Kwayltaek Lee</u>				23B. DATE SIGNED <u>12-5-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Kwayltaek Lee M.D.</u>				23D. ADDRESS <u>Mercy Hospital Staff</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-9-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	
24D. LOCATION <u>Baltimore</u>		24E. LOCATION <u>Maryland</u>		24F. LOCATION <u>Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212</u>	

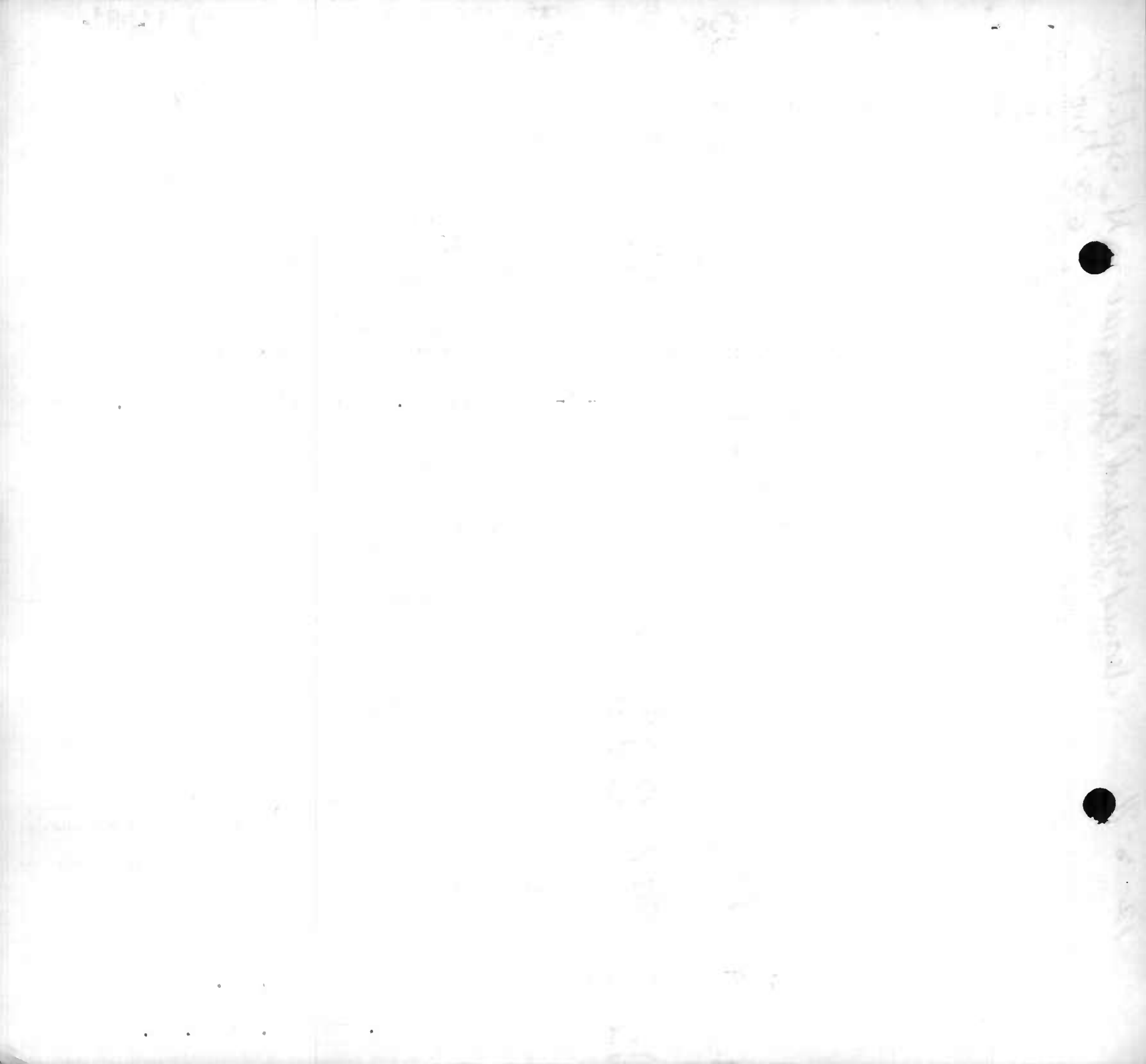


Released Medical Examiner - Dr. Spitz
FUNERAL DIRECTOR: IMPORTANT

12-3-77

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 11281	
<p>H-453 71 11281 CERTIFICATE OF DEATH Edna</p>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Heiland Marie		Dec. 3, 1971 8:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
UNION MEMORIAL HOSPITAL		CITY OF Baltimore 2731			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4124 PARKSIDE DR.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08-94	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Edward Rodney		14. MOTHER'S MAIDEN NAME Jane Samuels		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-01-0699		17. INFORMANT Joseph A. Munday 6210 Woodleigh Dr. Ellicott	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SEPSIS - UREMIA					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) PNEUMONIA - (C) ASCU					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-03-71 to 12-03-71 that (I) (we) last saw the deceased alive on 12-03-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jairo Ramirez				23B. DATE SIGNED 12-3-71	
23C. PHYSICIAN'S NAME (Type) JAIRO RAMIREZ				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL, CREMATION, REMOVAL, (Specify) Burial		24B. DATE 12/7/71		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION Baltimore, Md.		24E. STATE (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	



71 11282
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REG. NO. 71 11282

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Stanley Skiba		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 4, 1971 1:00 P M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year December 4, 1971 1:00 P M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2/22/1920		10. AGE (In years last birthday) 50 x	
11. BIRTHPLACE (State or foreign country) Trenton, New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		14B. KIND OF BUSINESS OR INDUSTRY Sun Cab	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unk		17. SOCIAL SECURITY NO. 140104582	
18. INFORMANT Edward F. Skiba		ADDRESS Trenton 857 Spruce St. NJ	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fibrinous pericarditis; (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: complicating acute myocardial infarct. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: *Werner U. Spitz* Deputy CHIEF MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER ☐
DATE SIGNED: December 5, 1971
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/71		24C. NAME of CEMETERY or CREMATORY Holy Cross Cem,		24D. LOCATION (City, town, or county) (State) Trenton New Jersey	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR R. E. J. J.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc., Balto. Md.		25D. ADDRESS 21214	

11-11-85

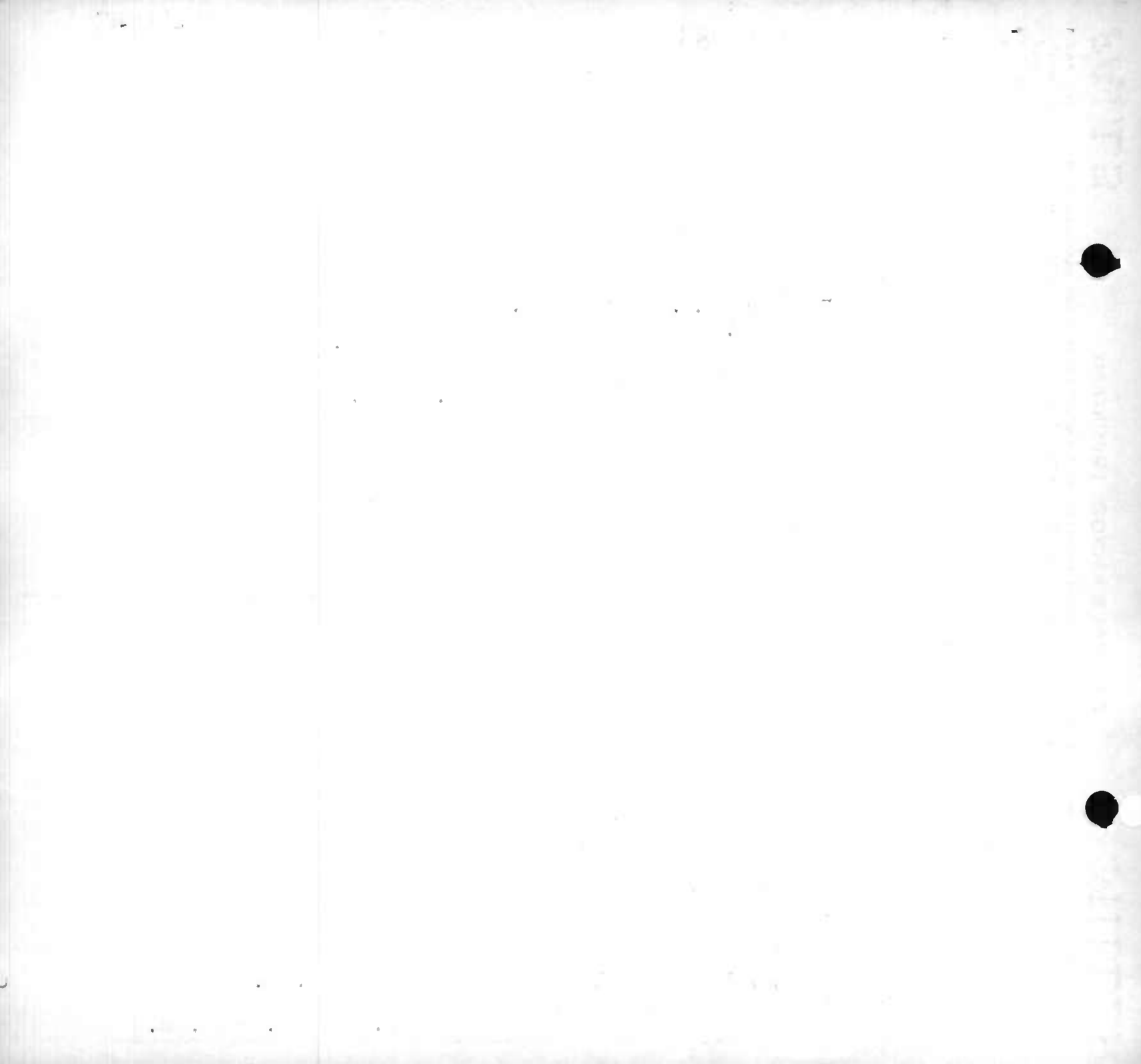
11-11-85



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

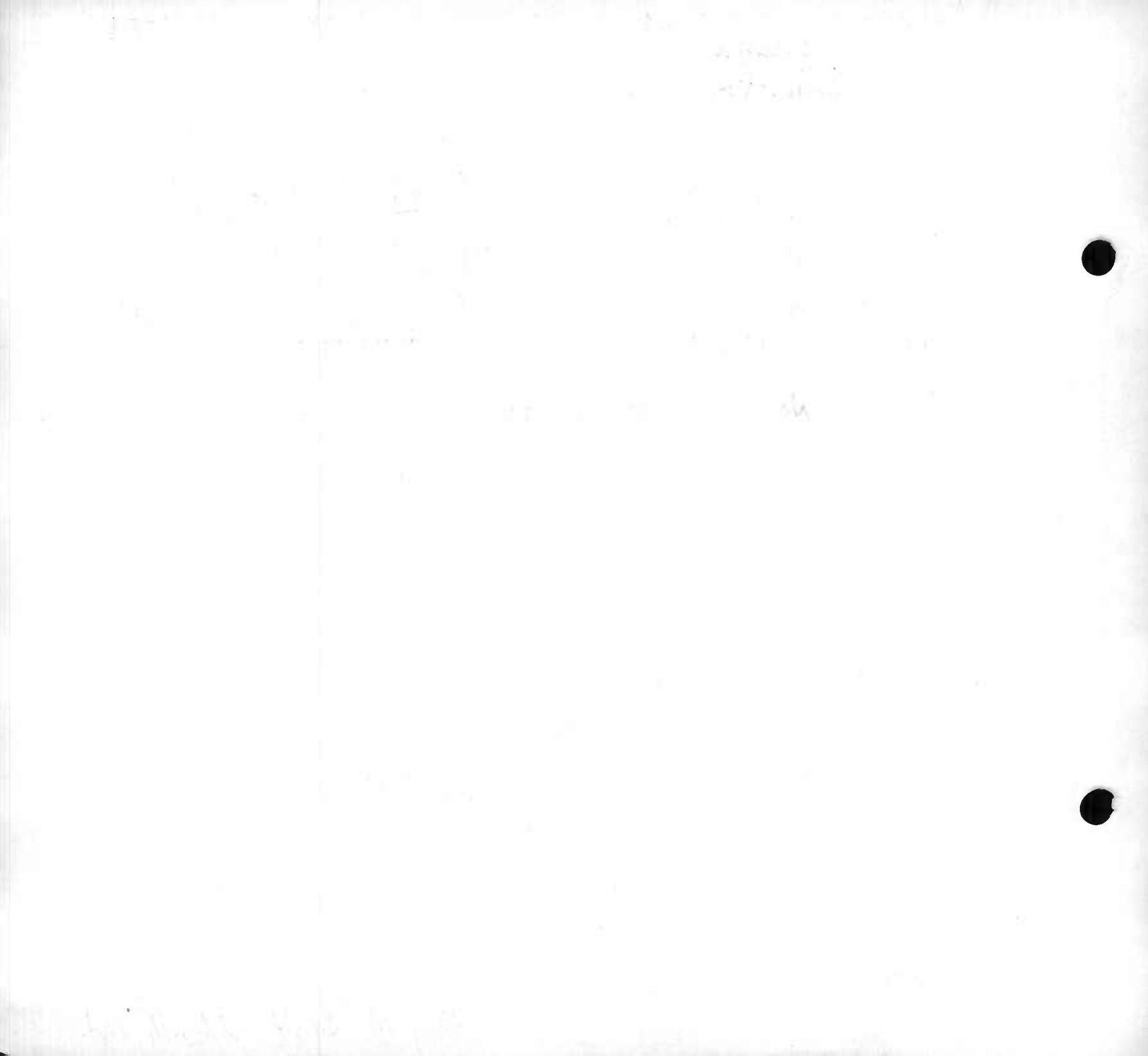
S-163 71 11283		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11283	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RICHARD J. SPARTANA		2. DATE AND HOUR OF DEATH Dec. 4, 1971 12:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO		5. 300	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 6313 HOLLYLANE APT. D			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-32	9. AGE (In years last birthday) 39	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK officer		10B. KIND OF BUSINESS OR INDUSTRY A.R. Sparta na Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ANTHONY SPARTANA		14. MOTHER'S MAIDEN NAME MARIA WALDHAUSER		12. CITIZEN OF WHAT COUNTRY? AMERICA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES		16. SOCIAL SECURITY NO. 219-30-7090		17. INFORMANT ADDRESS Mrs. Mary C. Spartana same	
18. 458,91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEVERE ANEMIA (B) DUE TO, OR AS A CONSEQUENCE OF: INTRAPERITONEAL BLEEDING (C) CIRRHOSIS OF LIVER, PORTAL HYPERTENSION, UREMIA, ELECTROLYTE IMBALANCE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. UNKNOWN UNKNOWN UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 12-03-1971 to 12-04-1971 that (H) (we) lost saw the deceased alive on 12-04-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rustum Irani		M.D. DEGREE M.D.		23B. DATE SIGNED 12.04.1971	
23C. PHYSICIAN'S NAME (Type) RUSTUM IRANI		M.D. DEGREE M.D.		23D. ADDRESS CHURCH HOME AND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/71		24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Ba lto. Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

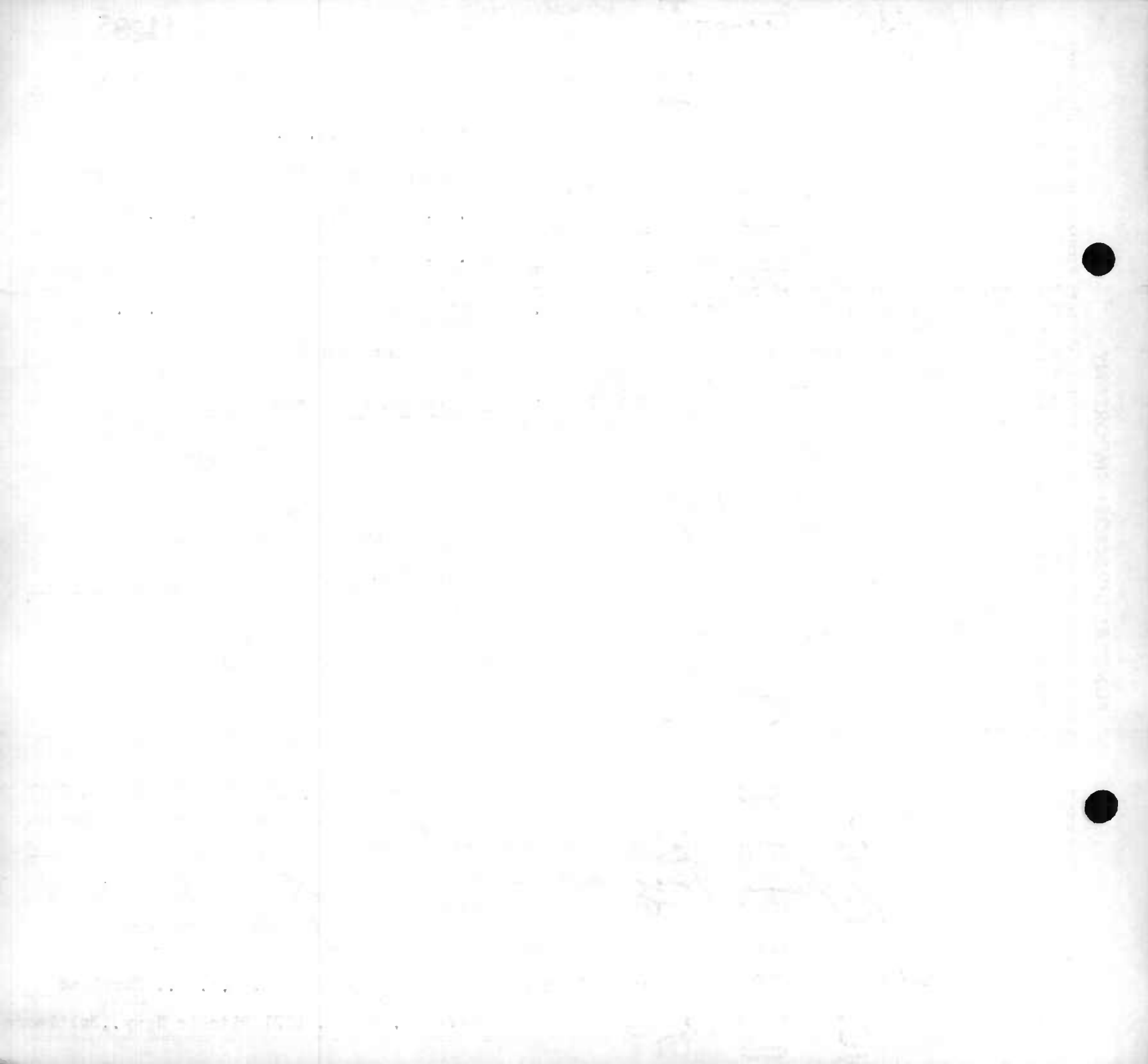
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11284	
S-160 71 11284		T	
BIRTH NO. Schaefer		1. NAME OF DECEASED (Type or Print) Schaefer, Annie Pickett	
2. DATE AND HOUR OF DEATH 1 Dec 71 805 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 38 GREEVE ST BALTS. Md 21201		A. STATE MARYLAND B. COUNTY CORROLL CO.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN WOODBINE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER WOODSMILL RD	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —	9. AGE (in years last birthday) 56
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kennynson Pickett		14. MOTHER'S MAIDEN NAME Elta Mae Braxton	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219 07 8814	
17. INFORMANT HUSBAND		ADDRESS As above	
18. 184.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma vagena & Bladder Tumor	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0 N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? N/A			
22. I certify that (I) (this hospital) attended the deceased from 30 Nov 1971 to 1 Dec 1971 that (I) (we) last saw the deceased alive on 1 Dec 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Edward B. Ostroff MD		23B. DATE SIGNED 1 Dec 71	
23C. PHYSICIAN'S NAME (Type) Edward B. Ostroff MD		23D. ADDRESS Univ. Hosp. Balts. Md 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE	
24C. NAME of CEMETERY or CREMATORY Morgan Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Woodbine Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Lysworth, Md.	



FUNERAL DIRECTOR: IMPORTANT

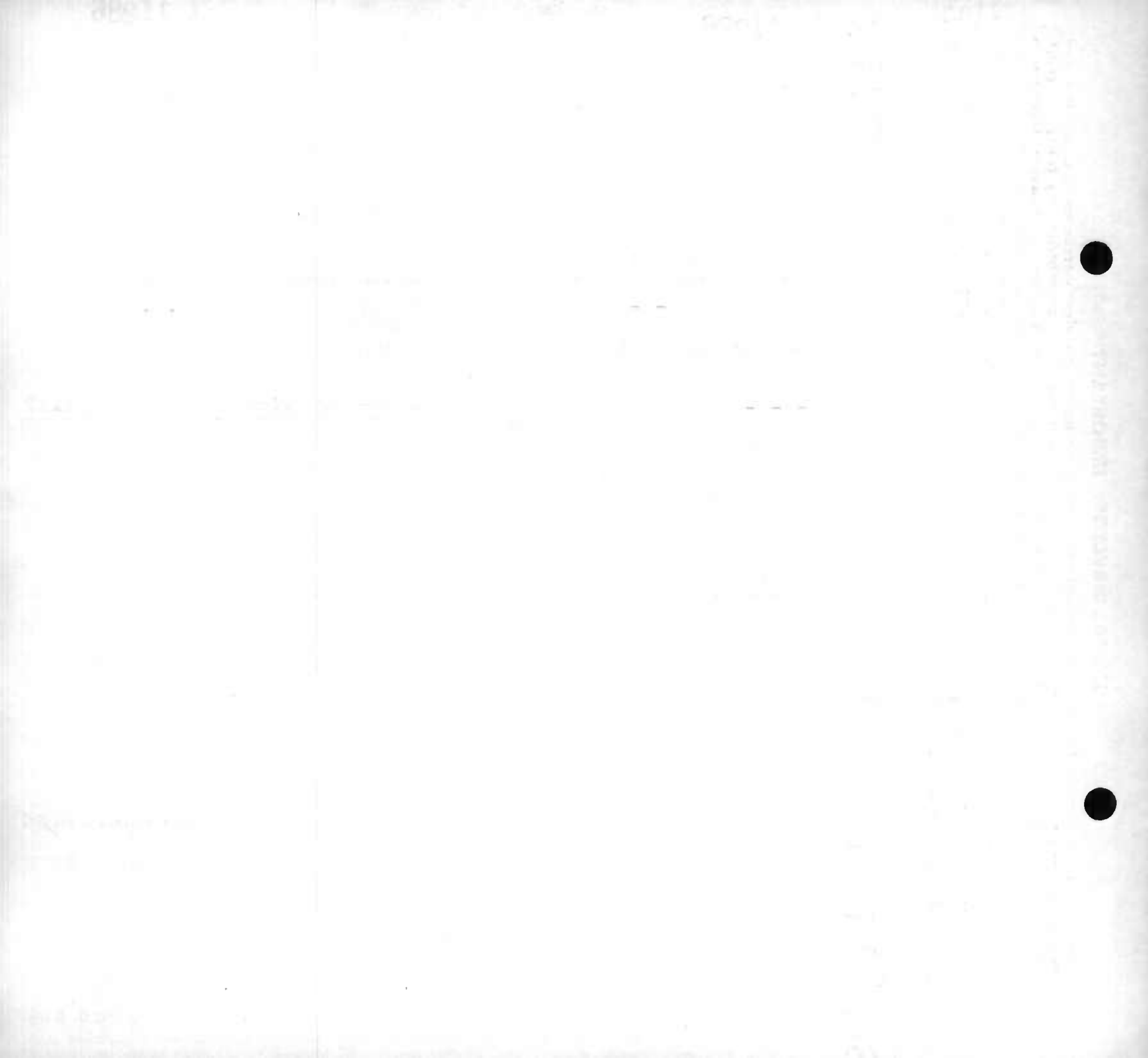
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530 71 11285		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11285	
1. NAME OF DECEASED (Type or Print) Norman Mazard Bennett				2. DATE AND HOUR OF DEATH Dec - 3 - 71 12 55 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 43 South Bul. Gen. Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY A.A.Co.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Bul. Gen. Hosp.				C. CITY OR TOWN Lombard Beach		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER Rt. 1, Box 256, Glen Burnie, Md. 21061			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1907	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Edwin Bennett				14. MOTHER'S MAIDEN NAME Emma Mazard			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 01 0164		17. INFORMANT ADDRESS Lillian Bennett (same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 199.0 IX-23-0.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gastrointestinal bleeding Metastatic Carcinoma of Liver or Pancreas (possible) (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov 23 19 71 to Dec 3 19 71 that (I) (we) last saw the deceased alive on Dec 3 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED Dec - 3 - 71		23C. PHYSICIAN'S NAME (Type) [Signature]	
23D. ADDRESS South Bul. Gen. Hosp.				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/71		24C. NAME of CEMETERY or CREMATORY Cedar Mill Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, A.A.Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce, 4001 Ritchie Hwy., Baltimore			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				71 11286	
K-500 71 11286				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ORA M. KANE		DECEMBER 4 1971 11 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3634 MALDEN AVE.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-31-1914	9. AGE (In years last birthday) 57	10. Under 1 Yr. Months Days 10 Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Rudasill			14. MOTHER'S MAIDEN NAME Morgan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	17. INFORMANT Frank Kane - #65 Timbergrove Rd 21117		
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) I BILATERAL PNEUMONIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: II BRONCHIAL CARCINOMA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-20 1971 to 12/4 1971 that (I) (we) last saw the deceased alive on 12/4 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 12/4/71	
23C. PHYSICIAN'S NAME (Type) CESAR VILARDO INTERN				23D. ADDRESS 33rd and Calvert St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/71		24C. NAME OF CEMETERY OR CREMATORY Lake View Memorial Pk.	
				24D. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Donovan Funeral Home 3818 Roland Ave	



FUNERAL DIRECTOR: IMPORTANT

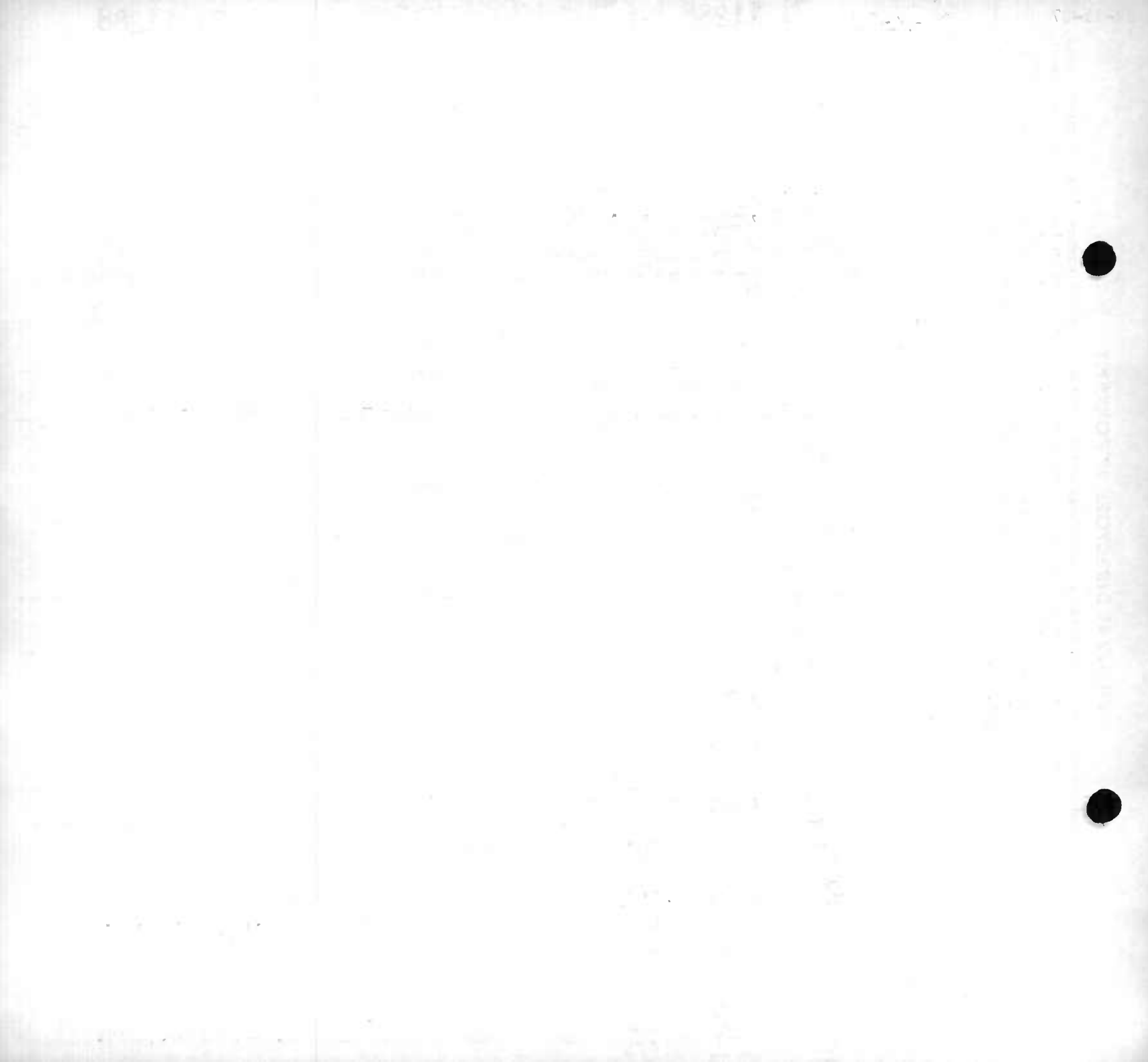
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-500 71 11287		BALTIMORE CITY HEALTH DEPARTMENT		71 11287	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WILLIAM F. MAHONEY		12/02/71		745 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bow Secours Hospital		A. STATE MARYLAND		B. COUNTY 2008	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 214 So. AUGUSTA AVE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/08/98	9. AGE (in years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10B. KIND OF BUSINESS OR INDUSTRY Eastern Stainless Steel		11. BIRTHPLACE (State or foreign country) MASS.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JEREMIAH MAHONEY		14. MOTHER'S MAIDEN NAME MARGARET FLYNN	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 218-07-3615		17. INFORMANT Mrs Gertrude T. Johnson	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 486X I Respiratory failure Major pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Major pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month) (Day) 1 Year) 1 Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 1, 1971 to December 2, 1971 that (I) (we) last saw the deceased alive on Dec. 1, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bandith M.D.		23B. DATE SIGNED 12-2-71			
23C. PHYSICIAN'S NAME (Type) BANDITH SUTTERATANA M.D.		23D. ADDRESS Bow Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/1971		24C. NAME of CEMETERY or CREMATORY Mt. Olive Cemetery	
24D. LOCATION Randallstown, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR F. Truman Schwab		25D. ADDRESS 3512 Frederick Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-152 71 11288		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 11288	
BIRTH NO.				1. NAME OF DECEASED Charles Spengler			
(Type or Print) Charles Spengler				2. DATE AND HOUR OF DEATH 12/3/71 7 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md.		B. COUNTY Baltimore	
31 Baltimore city hospitals				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4940 Eastern Avenue, Baltimore, Md. 21224				E. STREET AND NUMBER 208 Mace Ave			
5. SEX Male	6. RACE Caucasian White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/1894	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Charles Spengler				14. MOTHER'S MAIDEN NAME Johanna Etzel			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 216-03-0187		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Ave. 21224	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF: Pneumonia ~ 2-3 weeks			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: Diffuse Bronchiogenic Carcinoma ~ 15-16 months			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Chronic Dehydration			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/28/71 to 12/3/71 that (I) (we) last saw the deceased alive on 12/3/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ronald Banks, M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/3/71	
23C. PHYSICIAN'S NAME (Type) RONALD BANKS, M.D. DEGREE				23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. 21224 Baltimore city hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/71		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) Baltimore (State) Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.		25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 7111289	
P-620 7111289				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>PARRISH John E.</u>		2. DATE AND HOUR OF DEATH <u>5:30 Dec. 2 71</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>U.S.A.</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>3001 S. Hanover St. Baltimore</u> <u>43 Md. 21230</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>1708 Light Street</u>	
5. SEX <u>M</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-04</u>	9. AGE (In years last birthday) <u>67</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Dec.</u>		14. MOTHER'S MAIDEN NAME <u>Martha Wright</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war and dates of service) <u>Yes</u> <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>03-6614-A</u>		17. INFORMANT <u>Mrs. Sour</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, but heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Ischemia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, rise to the above cause UNDERLYING CONDITION last <u>Metastatic Carcinoma</u> <u>Fracture of Lt. upper extremity 6 wks</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18 (A-D)		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1708 Light St. Balt. Md. 21230</u>		21D. TIME OF INJURY (APPROX.) <u>Oct 27 1971</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>slip himself</u>		22. I certify that (I) (this hospital) attended the deceased from <u>11-30-71</u> to <u>12-2-71</u> and that (I) (we) last saw the deceased alive on <u>12-2-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Duck Kee Lee</u>		23B. DATE SIGNED <u>Dec. 2-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Duck. Kee Lee</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/6/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Mem. Park</u>	
24D. LOCATION (City, town, or county) <u>Dorsey, Howard Co. Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Md.</u>	
25C. FUNERAL DIRECTOR <u>McCully Funeral Home</u>		25D. ADDRESS <u>130 E. Fort Avenue</u>		25E. DATE <u>DEC 7 1971</u>	

RECEIVED

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11290	
W-420 71 11290					
BIRTH NO. 71-20744					
1. NAME OF DECEASED (Type or Print) Wills, BB			2. DATE AND HOUR OF DEATH 12/1/71 8:50 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY Maryland		
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hosp			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3420 Chessel Court		
5. SEX M	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/71	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 3 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Baltimore, Md Johns Hopkins		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Linda Wills		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiopneic shock (B) Probable CHD DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2h 4h
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8:30 AM 12/1/71 to 8:50 AM 12/1/71 that (I) (we) last saw the deceased alive on 12/1/71 8:50 A 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas Hoffman M.D.				23B. DATE SIGNED 12/1/71	
23C. PHYSICIAN'S NAME (Type) Thomas Hoffman M.D.				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12/2/71		24C. NAME OF CEMETERY OR CREMATORY Johns Hopkins Hospital	
24D. LOCATION 601 N Broadway, Balto., Md		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR R. E. Jones, Jr.	
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO		25D. ADDRESS		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

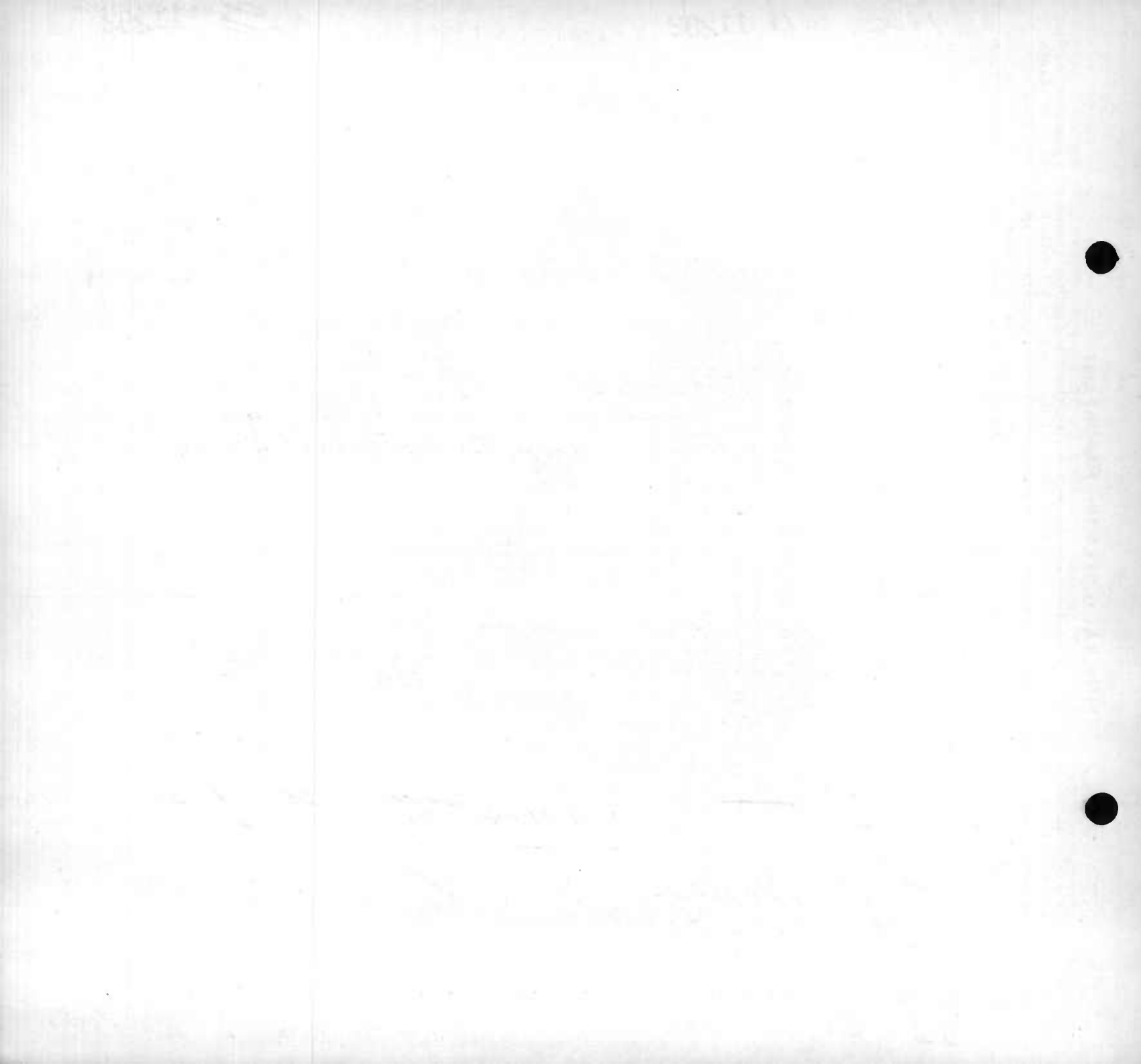
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11291
BIRTH NO. J-432 71 11291				
1. NAME OF DECEASED (Type or Print) <u>WYVETTA ALICE JOHLITZ</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 1, 1971</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2740</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>5906 Highgate Rd. 21215</u>		C. CITY OR TOWN <u>BALTO</u>
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>5906 Highgate Rd. 21215</u>
5. SEX <u>FEMALE</u>	6. RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20, 1924</u>	9. AGE (In years last birthday) <u>47</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHESTER GREEN</u>		
14. MOTHER'S MAIDEN NAME <u>HELEN WILDES</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>215-125812</u>		17. INFORMANT <u>CALVIN J. JOHLITZ</u>		
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal Pneumonia</u> <u>Carcinoma of Breast</u> <u>met.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Gracito V. Patricio</u>		23B. DATE SIGNED <u>12/1/71</u>		23C. PHYSICIAN'S NAME (Type) <u>GRACITO V. PATRICIO</u>
23D. ADDRESS <u>DEGREE</u>		23E. ADDRESS <u>DEGREE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-4-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDER MEMORIAL</u>
24D. LOCATION (City, town, or county) (State) <u>ECKRIDGE MARYLAND</u>		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1971</u>		
24F. NAME OF REGISTRAR <u>Robert E. Taylor, MD.</u>		24G. FUNERAL DIRECTOR <u>Wm. Cook Brooks Towson, Inc. Towson, Md.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

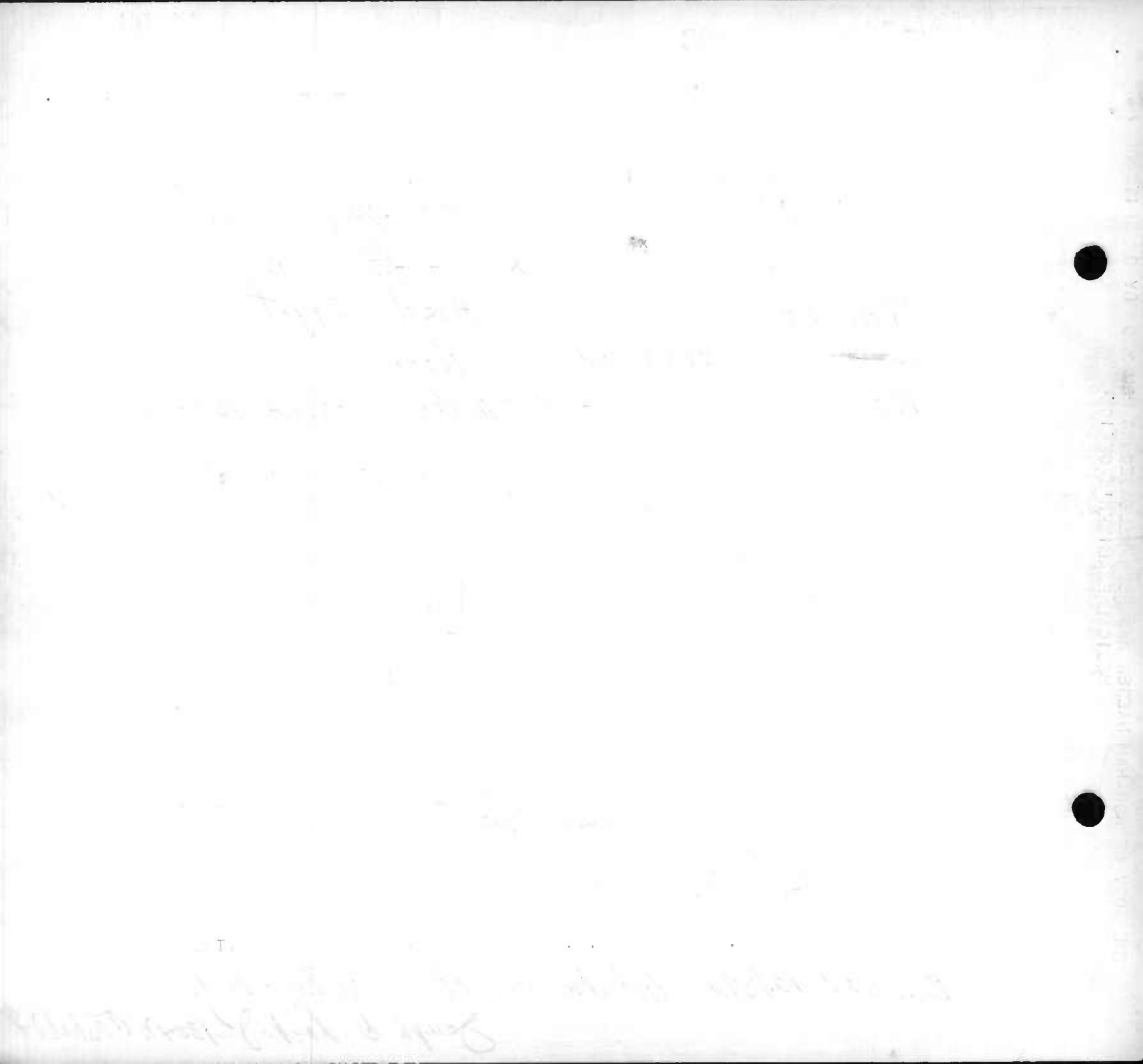
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 11292	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>CLARA Estelle HENSEL</i>			2. DATE AND HOUR OF DEATH <i>Dec. 1 - 1971 19:15 A. M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 UPLANDS Home For Church Women</i> <i>4501 Old Frederick Rd</i> <i>Baltimore, Md 21229</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>4501 Old Frederick Rd.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/18/1878</i>	9. AGE (In years lost birthday) <i>93</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>MARY LAND</i>	
13. FATHER'S NAME <i>WILLIAM HART</i>			14. MOTHER'S MAIDEN NAME <i>MARIETTA HATTON</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-54-3180</i>	17. INFORMANT <i>E. P. Langley</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH <i>congestive heart failure + ASCVD</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>none</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>		
19A. DATE OF OPERATION <i>none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1958</i> to <i>1 Dec 1971</i> , that (I) (we) last saw the deceased alive on <i>30 Nov 71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. K. Gallagher, Jr. MD</i>				23B. DATE SIGNED <i>1 Dec 71</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12-3-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>LOUDON PARK CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971			
25B. NAME OF REGISTRAR <i>Robert E. Bailey, M.D.</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson, Inc.</i>			



MEDICAL EXAMINER'S OFFICE
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-206 71 11293		BALTIMORE CITY HEALTH DEPARTMENT		71 11293	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) ABRAHAM NAESEA			2. DATE AND HOUR OF DEATH 12-04-71 7:10 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE MARYLAND B. COUNTY 704		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE			6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR			8. DATE OF BIRTH 04-06-95		9. AGE (in years last birthday) 76
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) ADEN EGYPT.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ABRAHAM NAESEA ORTHMAN			14. MOTHER'S MAIDEN NAME NORA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 218-32-3047		17. INFORMANT Mildred NAESEA 1504 N. Luzerne St
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 493X1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CAUSE OF DEATH Respiratory Arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-04 19 71 to 12-04-19 71 that (I) (we) last saw the deceased alive on 12-04 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert D. Kramer M.D.			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ROBERT D. KRAMER M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12/8/71		24C. NAME OF CEMETERY OR CREMATORY Catholics Mem. PK
24D. LOCATION Catholics M.D.			24E. DATE REC'D BY HEALTH DEPT. DEC 7 1971		
25A. NAME OF REGISTRAR Robert C. Taylor M.D.			25B. FUNERAL DIRECTOR Joseph B. Lockard 1304 N. Central		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. 71 11294					REG. NO. 71 11294				
1. NAME OF DECEASED (Type or Print) ROSS NATHANIEL PHILLIP N.					2. DATE AND HOUR OF DEATH Dec 5/1971 7:20 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 323					A. STATE MD.				
					B. COUNTY 1204				
C. CITY OR TOWN Baltimore					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER 203 E. 23 ST				
5. SEX M.	6. RACE N.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/1910		9. AGE (in years last birthday) 61		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Engineer			10B. KIND OF BUSINESS OR INDUSTRY School (BALTD)			11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME PHILIP ROSS					14. MOTHER'S MAIDEN NAME MARY LONG				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-18-9695		17. INFORMANT ELNA ROSS 203 E. 23rd ST				
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Respiratory failure									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic lesion & involvement of poss. higher cervical spinal cord (B) DUE TO, OR AS A CONSEQUENCE OF: Terminated metastatic ca (Poss. Lung) (C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION Nov. 30/71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Inoperable pain			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from Nov. 29 1971 to Dec 5 1971 that (1) (we) lost saw the deceased alive on Dec 5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE M. Sarkarath M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED Dec 5/71	
23C. PHYSICIAN'S NAME (Type) Mehdi Sarkarath M.D.					23D. ADDRESS 5605 B. The Alameda 212 39				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12/9/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary			24D. LOCATION (City, town, or county) (State) B. A. County Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Joseph E. Locks Jr. 13047 Central			

C-652		71 11295		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		71 11295			
BIRTH NO.				REG. NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH							
BERNARD CARRINGTON				Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month		Day		Year	
						December		2,		1971	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION				3. DATE PRONOUNCED DEAD				Month		Day	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				December				2,		1971	
33 Johns Hopkins Hospital				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				A. STATE		B. COUNTY	
				Maryland						301	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH		10. AGE (In years)		11. Under 1 Yr. 12. Under 24 Hrs.		E. STREET AND NUMBER					
Aug 31, 1928		4-3		Months Days Hours Min.		284 South Spring Court					
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME					
Maryland				U.S.		William Carrington					
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY				15. MOTHER'S MAIDEN NAME			
Street Clerk Store				Store				Hilda Sorrell			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS					
Yes				W. W. 77-2202		Aura Carrington - 284 S. Spring					
19. CAUSE OF DEATH				20. DATE OF OPERATION							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				21. AUTOPSY? (Yes or No)							
Arteriosclerotic cardiovascular disease				Yes							
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				DUE TO, OR AS A CONSEQUENCE OF:							
				(B) DUE TO, OR AS A CONSEQUENCE OF:							
				(C) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED				22F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				DATE SIGNED			
Charles S. Springate, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				December 3, 1971			
EXAMINER'S NAME (Type)				ASSOCIATE MEDICAL EXAMINER							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial				12-7-71		Mt. Calvary Cem		A. A. County, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 7 1971				Robert E. Galt, M.D.		Milton C. Elchson		1129 N. Calver			

H 620

71 11296

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11296
REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Harris

2. DATE
OF DEATHKnown ☐
Estimated ☒

Month Day

Year

Hour

December 4,

1971

5:00 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

119 W. Henrietta Street

3. DATE
PRONOUNCED DEAD

Month Day

Year

Hour

December 4,

1971

6:00 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

2301

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

6-30-1928

10. AGE (In years
lost birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

119 W. Henrietta Street

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Cora Lee Moore

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, near unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Alexander Funeral Home - Charlotte, N. C.

19. 371.8

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Fatty alteration of liver.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 5, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

12-10-71

24C. NAME of CEMETERY or CREMATORY

York Memorial

24D. LOCATION (City, town, or county)

Charlotte, N. C.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 7 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Alexander Funeral Home - Charlotte, N. C.

Charles Fox Forward Home

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 11297		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11297	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Eunice Alston</i>		2. DATE AND HOUR OF DEATH <i>12/4/71</i> <i>5 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <i>BALTO</i> B. COUNTY <i>BALTO</i>		C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>U.S. Public Health Service Hospital</i> <i>Wyman Pk Drive + 31st St.</i>		E. STREET AND NUMBER <i>721 "I" St</i>		F. BALTO MD. <i>21219</i>	
5. SEX <i>F</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-23-98</i>	9. AGE (in years last birthday) <i>72</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>S.C.</i>	
13. FATHER'S NAME <i>Monroe Holmes</i>		14. MOTHER'S MAIDEN NAME <i>Alice Crosby</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Records - US PHS Hospital - Balto</i>	
18. <i>1966-01</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac arrest</i>		<i>immediate</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Metastatic cervical carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF: <i>years</i>			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>NONE</i>					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/4</i> 19 <i>71</i> to <i>12/4</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>12/4</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stephen Fris MD</i>		DEGREE <i>MD</i>		23B. DATE SIGNED <i>12/4/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Stephen Fris MD</i>		DEGREE <i>MD</i>		23D. ADDRESS <i>USPHS Hosp Balt Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-8-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 7 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>Mary-Elizabeth Law</i>	
				ADDRESS <i>802 Madison Ave.</i>	





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BALTIMORE CITY HEALTH DEPARTMENT

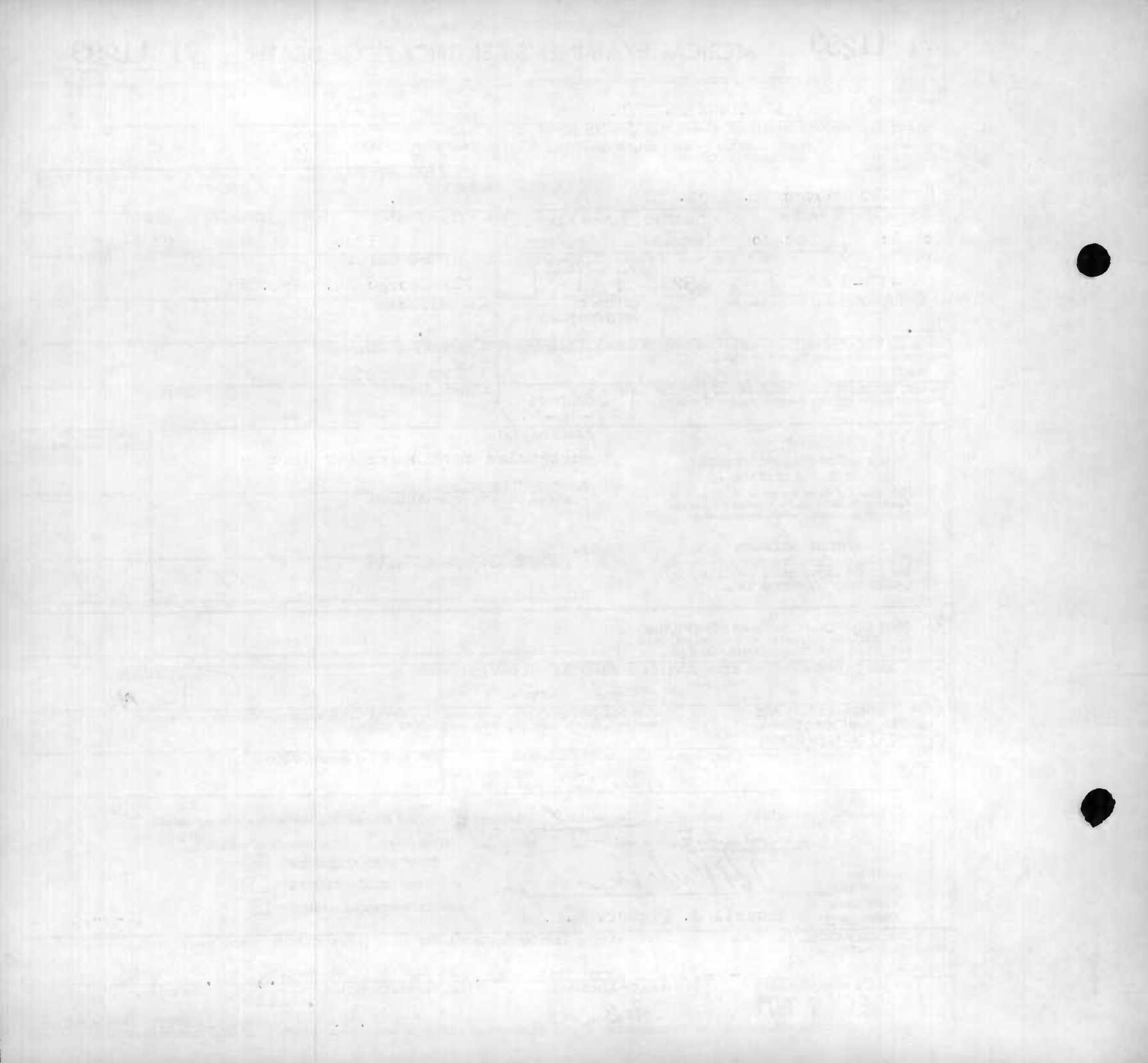
71 11299

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11299

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FLORANCE PETTIGREW		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 725 George St. Apt. 5H		3. DATE PRONOUNCED DEAD Month Day Year 12 5 1971 10:45p M.	
6. SEX female		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 6-13-19		10. AGE (In years lost birthday) 52	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Iva Gracin	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 217-24-5180	
18. INFORMANT Leroy Pettigrew		ADDRESS same	
19. 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11300	
BIRTH NO. 71 11300		1. NAME OF DECEASED (Type or Print) EDWARD SPRIGGS		2. DATE AND HOUR OF DEATH 12-4-71 9:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL Hospital 48827 LINDEN AVE.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 704 BRADLEY ST. - 21201		
5. SEX M	6. RACE N N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27-95	9. AGE (In years lost birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTO. CITY	
13. FATHER'S NAME Richard Spriggs			14. MOTHER'S MAIDEN NAME Sarah Knox		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 7-18-18*3-19		16. SOCIAL SECURITY NO. 212-09-4444		17. INFORMANT ADDRESS (NIECE) LILLIAN MORRIS - SAME	
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. STROKE Emphysema, bilateral, moderately severe			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 24 hrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2-1-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 12-4-71 19 71 to 12-4 19 71 that (I) (we) last saw the deceased alive on 12-4-71 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry Sacks MD				23B. DATE SIGNED 12-4-71	
23C. PHYSICIAN'S NAME (Type) HENRY SACKS MD				23D. ADDRESS MARYLAND GEN. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR V. Bailey			
25D. ADDRESS Kelson F. H. 1348 Calhoun Street					

EMPHATICALLY 8.10.1961, Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **71 11301**

BIRTH NO. **71 11301**

1. NAME OF DECEASED
(Type or Print)

RODNEY BRADFORD

2. DATE AND HOUR OF DEATH

12-6-71

7²⁰ A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL of BALTIMORE

42

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2906 PARKWOOD AVE 21217

5. SEX

MALE

6. RACE

BLACK

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10-13-56

9. AGE (in years last birthday)

15

10. Under 1 Yr. Months

11. Under 24 Hrs. Days

12. Under 24 Hrs. Hours

13. Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SCHOOL

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY

UNITED STATES

13. FATHER'S NAME

WILLIAM BRADFORD SR.

14. MOTHER'S MAIDEN NAME

EDMONDS, (HELEN)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

HELEN BRADFORD

ADDRESS

SAME

18. **207.01**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ACUTE LEUKEMIA

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7 1/2 MONTHS

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from **12-2** 19 **71** to **12-6** 19 **71** that (1) (we) lost saw the deceased alive on **12-6** 19 **71** and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

ELLIOTT R. PEARL MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12-6-71

23C. PHYSICIAN'S NAME (Type)

ELLIOTT R. PEARL MD

23D. ADDRESS

JOHNS HOPKINS HOSPITAL BALTIMORE, MD

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/11/71

24C. NAME OF CEMETERY or CREMATORY

MT Auburn Cemetery

24D. LOCATION

Baltimore, Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 7 1971

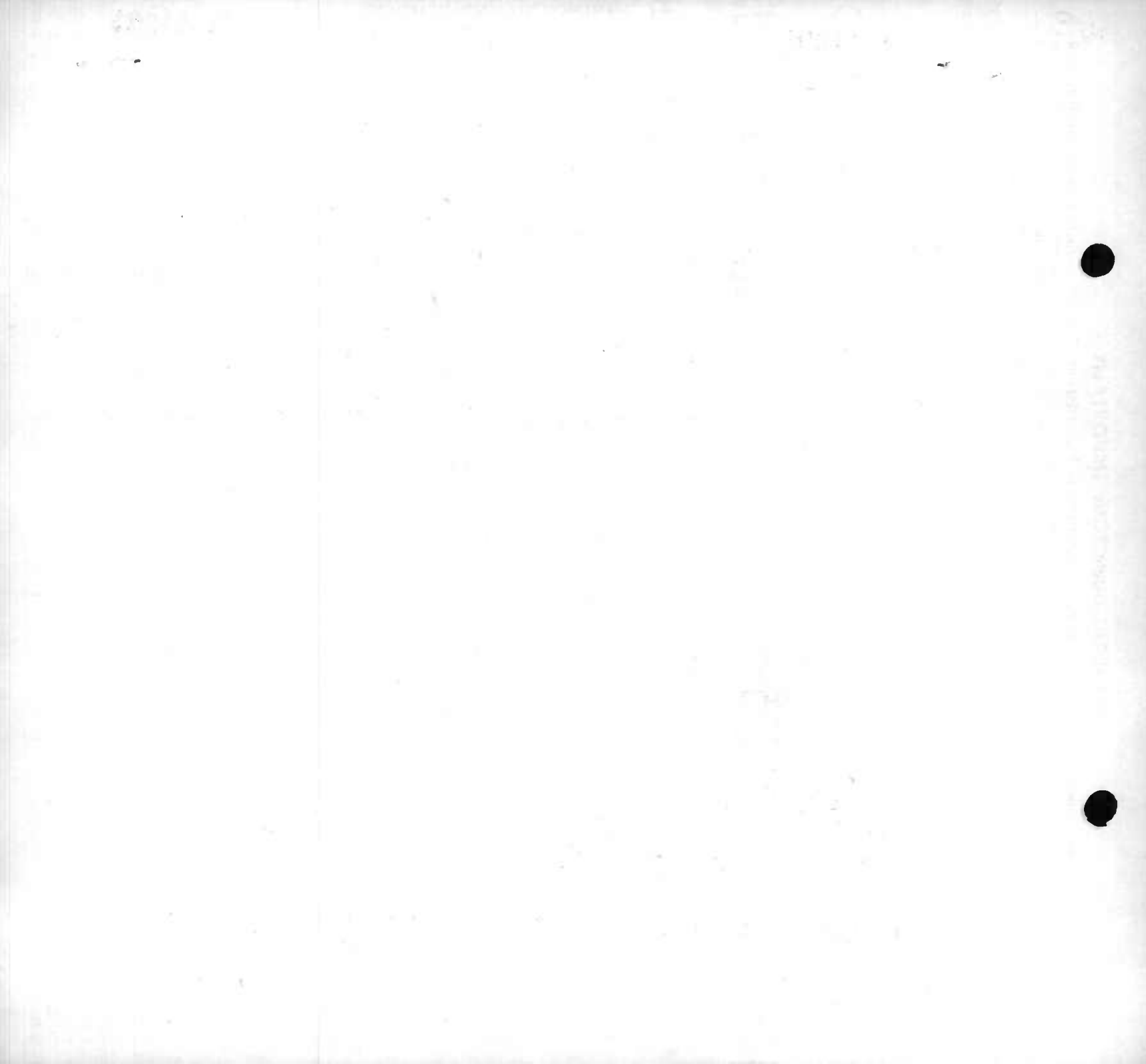
25B. NAME OF REGISTRAR

John E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11302	
BIRTH NO. 71 11302		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ELLIOTT WARREN			2. DATE AND HOUR OF DEATH 12/2/71 2:15 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOOD SAMARITAN HOSPITAL 4-5			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTO. B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 925 E PRESTON ST. 2102 100		
5. SEX Male	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/19	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME ELLIOTT WARREN		
14. MOTHER'S MAIDEN NAME SARAH			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 215-12-9284		
17. INFORMANT WILLIE WARREN			ADDRESS 2558 W. PRATT ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 398X1 ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Rheumatic Carditis DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary Embolus.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/27 19 71 to 12/2 19 71, that (I) (we) last saw the deceased alive on 12/2/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. DOUGLAS LEE				23B. DATE SIGNED 12/2/71	
23C. PHYSICIAN'S NAME (Type) J. DOUGLAS LEE				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-4-71		24C. NAME OF CEMETERY or CREMATORY MT. AUBURN	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR CHARLES H. RICE 661 W. BARKE ST.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

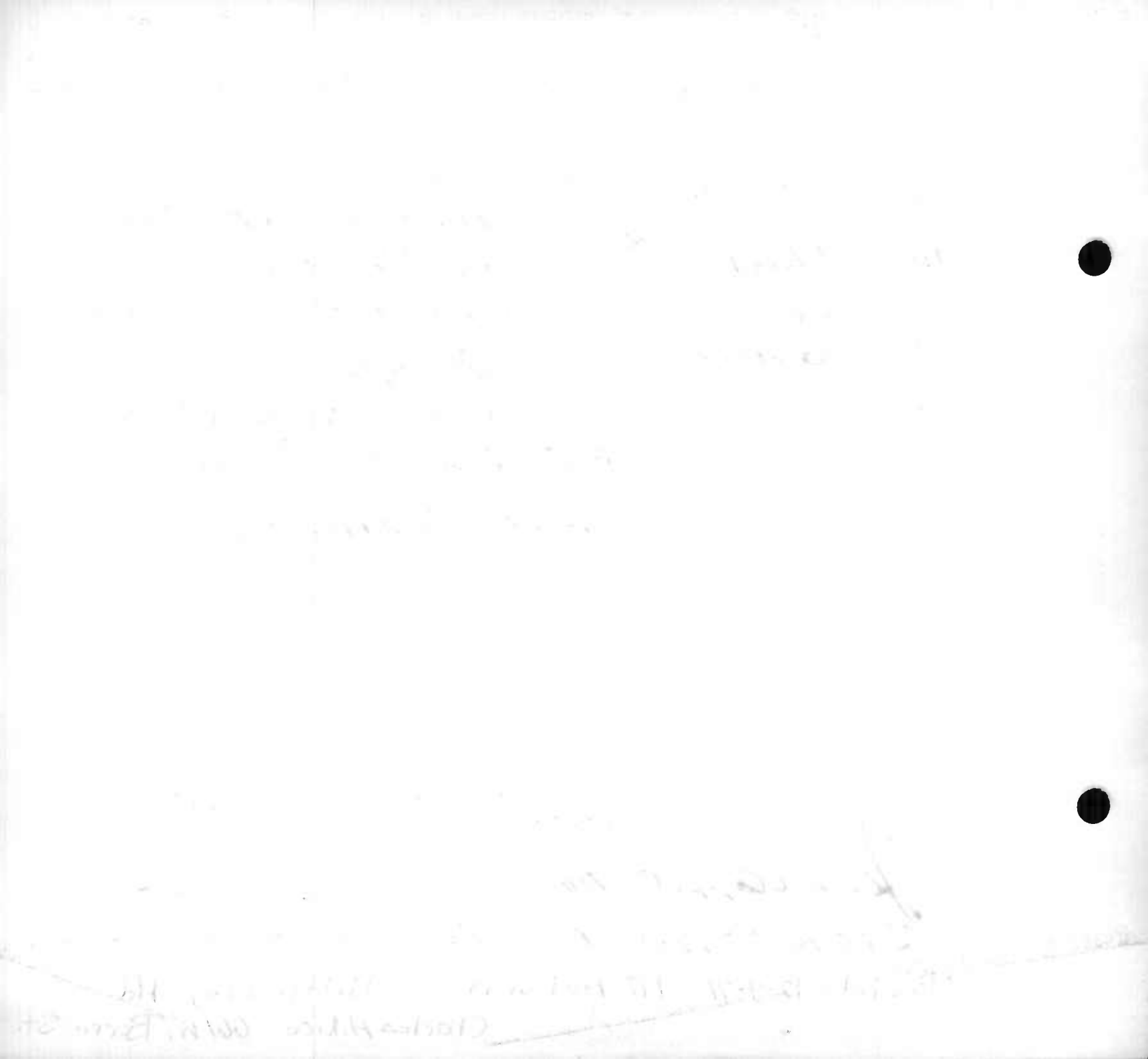
71 11303		BALTIMORE CITY HEALTH DEPARTMENT		71 11303	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Robert Benbow		2. DATE AND HOUR OF DEATH Dec 2 1971 2:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY 1601			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital 38		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1024 Bennett Place			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1910	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME unk.		14. MOTHER'S MAIDEN NAME unk.		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown No		16. SOCIAL SECURITY NO. 217-18-0032		17. INFORMANT Nellie Waith ADDRESS 1228 Rankin St	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenie, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Post-Cardiac Arrest (B) Right cerebral hemisphere - stroke DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Left hemisphere - stroke				5 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/30/71 to 12/2/71 that (I) (was) last saw the deceased alive on 12/2/71 and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 12/2/71		23C. PHYSICIAN'S NAME (Type) David B. Posner md.	
23D. ADDRESS University Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12-6-71		24C. NAME OF CEMETERY or CREMATORY MT. AUBURN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Charles A. Rice ADDRESS 661 W. Bane St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

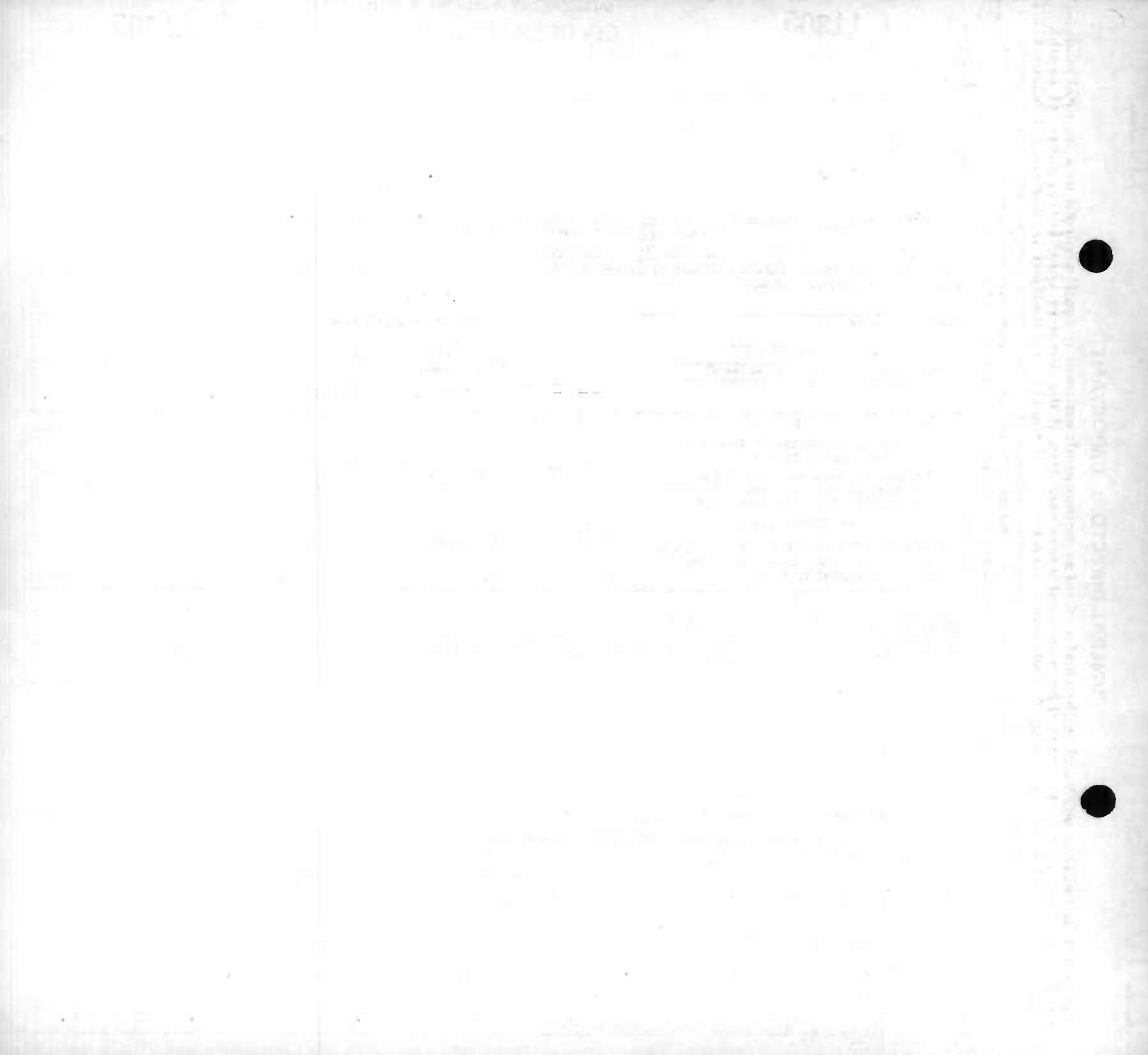
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11304	
BIRTH NO. 71 11304				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Nelson E. Craighead			2. DATE AND HOUR OF DEATH Dec 4 1971 7:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2101		
FULL NAME OF HOSPITAL OR INSTITUTION Univ of Maryland Hosp			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE Colored			8. DATE OF BIRTH 8/3/18		9. AGE (In years last birthday) 53
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME John Craighead			14. MOTHER'S MAIDEN NAME Georgia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) UNK			16. SOCIAL SECURITY NO.		17. INFORMANT Anna Bell Craighead
18. 395.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Pulmonary Edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Aortic Insufficiency			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/3/71 19 to 12/4 1971 that (I) (we) lost saw the deceased alive on 12/4/71 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome Kocpnel MD				23B. DATE SIGNED 12/4/71	
23C. PHYSICIAN'S NAME (Type) Jerome Kocpnel MD				23D. ADDRESS Univ. of Maryland Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-9-71		24C. NAME OF CEMETERY or CREMATORY MT. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971			
25B. NAME OF REGISTRAR Robert E. Farber, MD.		25C. FUNERAL DIRECTOR Charles H. Rice			
25D. ADDRESS 661 W. Barre St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11305	
<div style="display: flex; justify-content: space-between;"> 6351 71 11305 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>Andrew Gardner</u>			2. DATE AND HOUR OF DEATH <u>12-4-71</u> <u>8:55</u> a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1802</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>115 N. Carlton St.</u>		
5. SEX <u>Male</u>	6. RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1900</u>	9. AGE (in years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Phillip Gardner</u>		
14. MOTHER'S MAIDEN NAME <u>Catherine Fisher</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>A 219-01-2689</u>			17. INFORMANT ADDRESS <u>Mildred Gardner 1010 W. Saratoga St.</u>		
18. <u>440.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Diffuse consolidation of both lungs.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Branchial pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized arteriosclerosis</u> (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-29-</u> <u>1971</u> to <u>12-4-71</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>12-4-71</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Shawn Malek</u> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Shawn N. Malek</u> DEGREE				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/8/71</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Stevens Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles A. Rice 661 W. Barre St.</u>			



1
D 512

71 11306

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11306

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ronald V. Dempsey		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year December 4, 1971 5:20 PM M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year December 4, 1971 5:20 PM M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1/29/48		10. AGE (in years lost birthday) 23	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy Barnes		14. STREET AND NUMBER 2718 Loretta Ave.	
15. MOTHER'S MAIDEN NAME Alice Davis		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 218-48-2869		18. INFORMANT ADDRESS Alice Davis 2718 Lauretta Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple gunshot wounds of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 12		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.) automobile		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Cross and Leadenhill ? 2301	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12/4/71 5:00 PM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? shot and dumped		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED December 5, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. a Barre St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

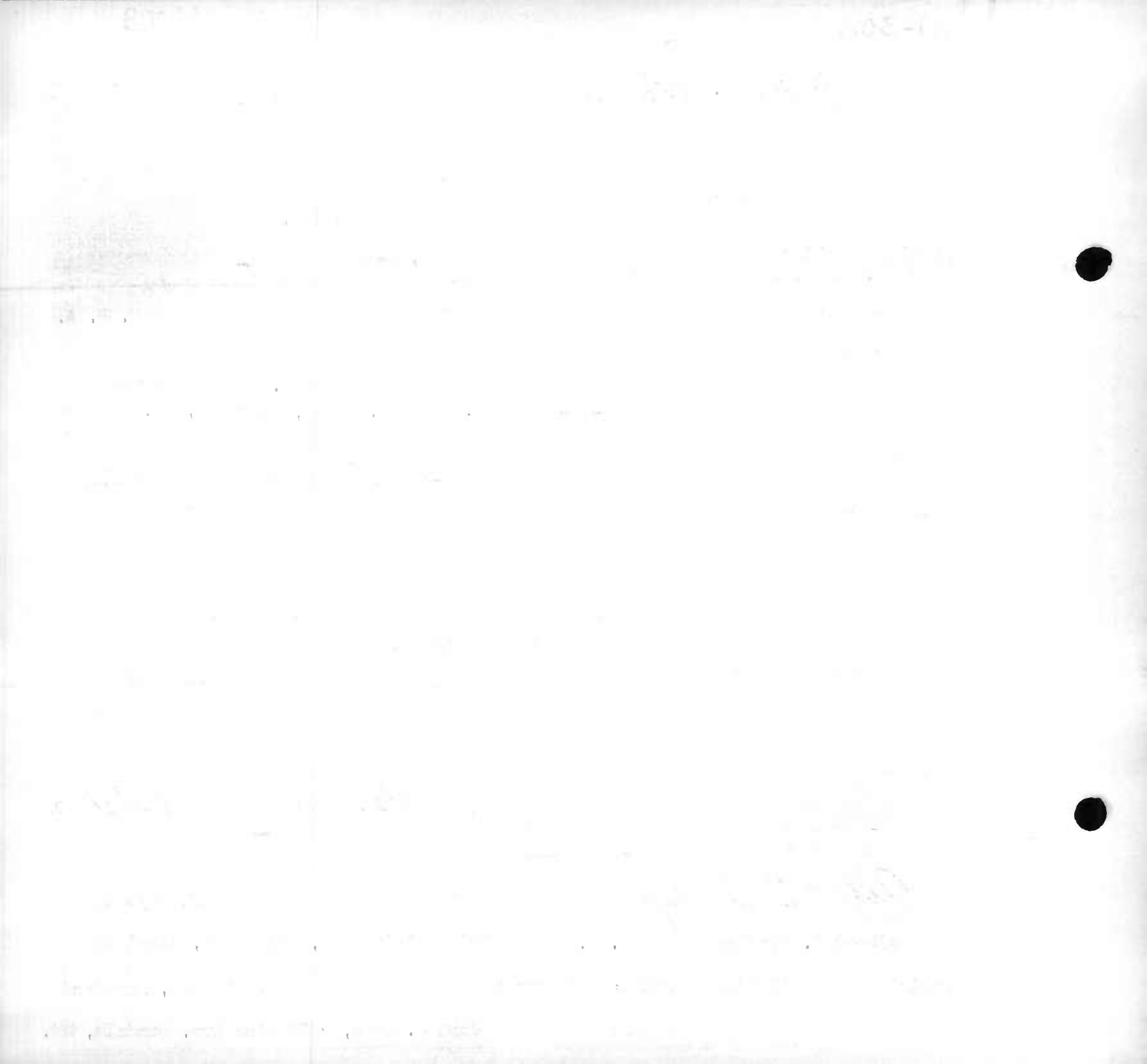
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11307	
W-450 71 11307		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Helen E. Whalen		2. DATE AND HOUR OF DEATH December 4, 1971 7:00 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45 Good Samaritan		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2019 Wareham Road	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1903
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	9. AGE (In years last birthday) 68
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Amann		14. MOTHER'S MAIDEN NAME Elizabeth Roberts	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-0452	
17. INFORMANT (Brother) Mr. Ricard Amann		2019 Wareham Road Dundalk, Md. 21222	
18. 146.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Metastatic carcinoma in abdomen with ascites (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 2 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Tonsillar carcinoma, treated with Cobalt 18 months			
19A. DATE OF OPERATION 11/3/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED diagnostic laparotomy	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) XXXX	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) XXXX		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) XXXX	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? XXXX	
22. I certify that (X) (this hospital) attended the deceased from November 22, 1971 to December 4, 1971 , that (I) (we) last saw the deceased alive on December 3, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE George H. Sack, Jr.		23B. DATE SIGNED 12/4/71	
23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D.		23D. ADDRESS 5600 Loch Raven Blvd., Balto. Md., '12	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-7-71	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971	25B. NAME OF REGISTRAR Robert E. Fisher, Md.	25C. FUNERAL DIRECTOR ADDRESS John J. Duda 7922 Wise Ave. Dundalk, Md. 21222	



FUNERAL DIRECTOR: IMPORTANT

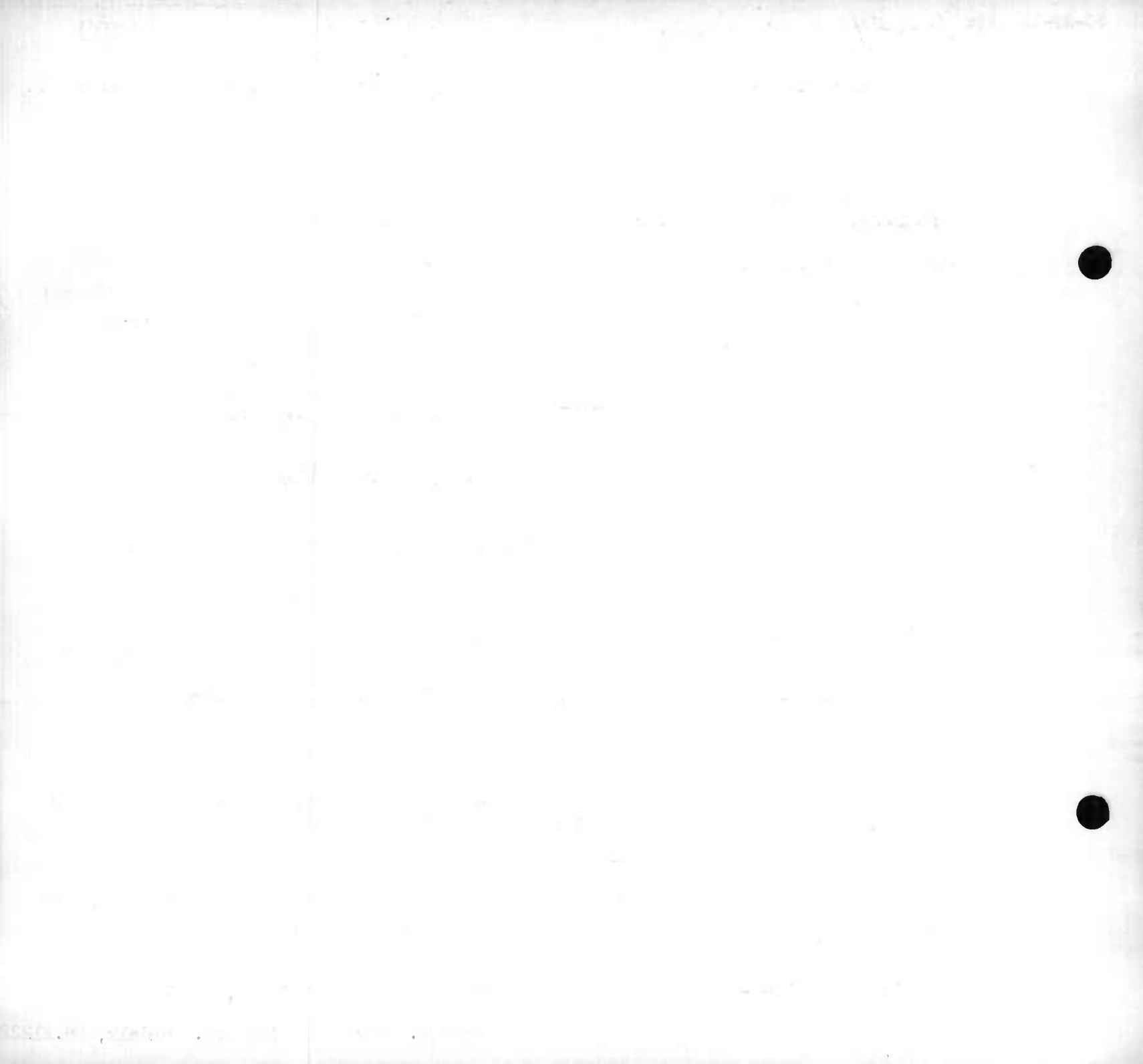
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> W-300 71 11308 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 71 11308
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) MAY B. WHITE		2. DATE AND HOUR OF DEATH 12/3/71 3 ⁴⁵/_P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY BALTO 5300 C. CITY OR TOWN Rosdale D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2132 Boundary Ave.
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 19, 1894		9. AGE (In years lost birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Richard Brooker		14. MOTHER'S MAIDEN NAME _____
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 060-03-5735
17. INFORMANT (Son) 430 S. Cornwall Street Mr. James R. White, Baltimore Md. 21224		
18. 486X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Acute Pneumonia DUE TO, OR AS A CONSEQUENCE OF: 12 hours (B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Heart Failure, Ascorbic Acid Deficiency, Chronic Bronchitis		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I certify that (I) (this hospital) attended the deceased from 11/29/1969 to 12/3/1971 that (I) (we) last saw the deceased alive on 12/3/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 12/3/71
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley M. D.		23D. ADDRESS 4900 Belair Road, Baltimore, Maryland
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/7/71	24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971
25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-634		71 11309		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 11309	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Edith F. Hrdlicka		2. DATE AND HOUR OF DEATH December 3, 1971		4:00 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2974 Sollers Point Road 21222					
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-09	9. AGE (in years last birthday) 62	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Robert Seivard			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-32-5407		17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I 1627 I INTERCEREBRAL HEMORRHAGE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1 day (B) DUE TO, OR AS A CONSEQUENCE OF: 1 month (C) DUE TO, OR AS A CONSEQUENCE OF: lung Ca				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 12-2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-2 19 71 to 12-3 19 71 that (I) (we) last saw the deceased alive on 12-3 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Leon Landau				23B. DATE SIGNED December 3, 1971					
23C. PHYSICIAN'S NAME (Type) Leon Landau		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.		25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md. 21222					



CERTIFICATE OF DEATH

REG. NO.

71 11310

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Dunn, Dolores V

(Eloise)

2. DATE AND HOUR OF DEATH

Dec 3 1971 1:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

220 S. Woodwell Road 21222

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6/16/21

9. AGE (In years
last birthday)

50

10. If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Perry

14. MOTHER'S MAIDEN NAME

Matilda Hughes

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-14-3237

17. INFORMANT

BCH-Records:

4940 Eastern Avenue

Baltimore, Maryland 21224

ADDRESS

18.

250.91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute myocardial
infarction

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Diabetes mellitus

(C)

K K a a

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

K K a a

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 1 1971 to Dec 3 1971
that (I) (we) last saw the deceased alive on Dec 3 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. E. Menitove, MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Dec 3 1971

23C. PHYSICIAN'S
NAME (Type)

JAY E. MENITOVE, MD

23D. ADDRESS

Balt. City Hosp. 4940 Eastern Ave.
Balt. Md 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-6-71

24C. NAME of CEMETERY or CREMATORY

Holly Hill Memorial Gardens

24D. LOCATION

(City, town, or county)

White Marsh, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 7 1971

25B. NAME of REGISTRAR

John J. Duda

25C. FUNERAL DIRECTOR

ADDRESS

John J. Duda 7922 Wise Ave. Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11310

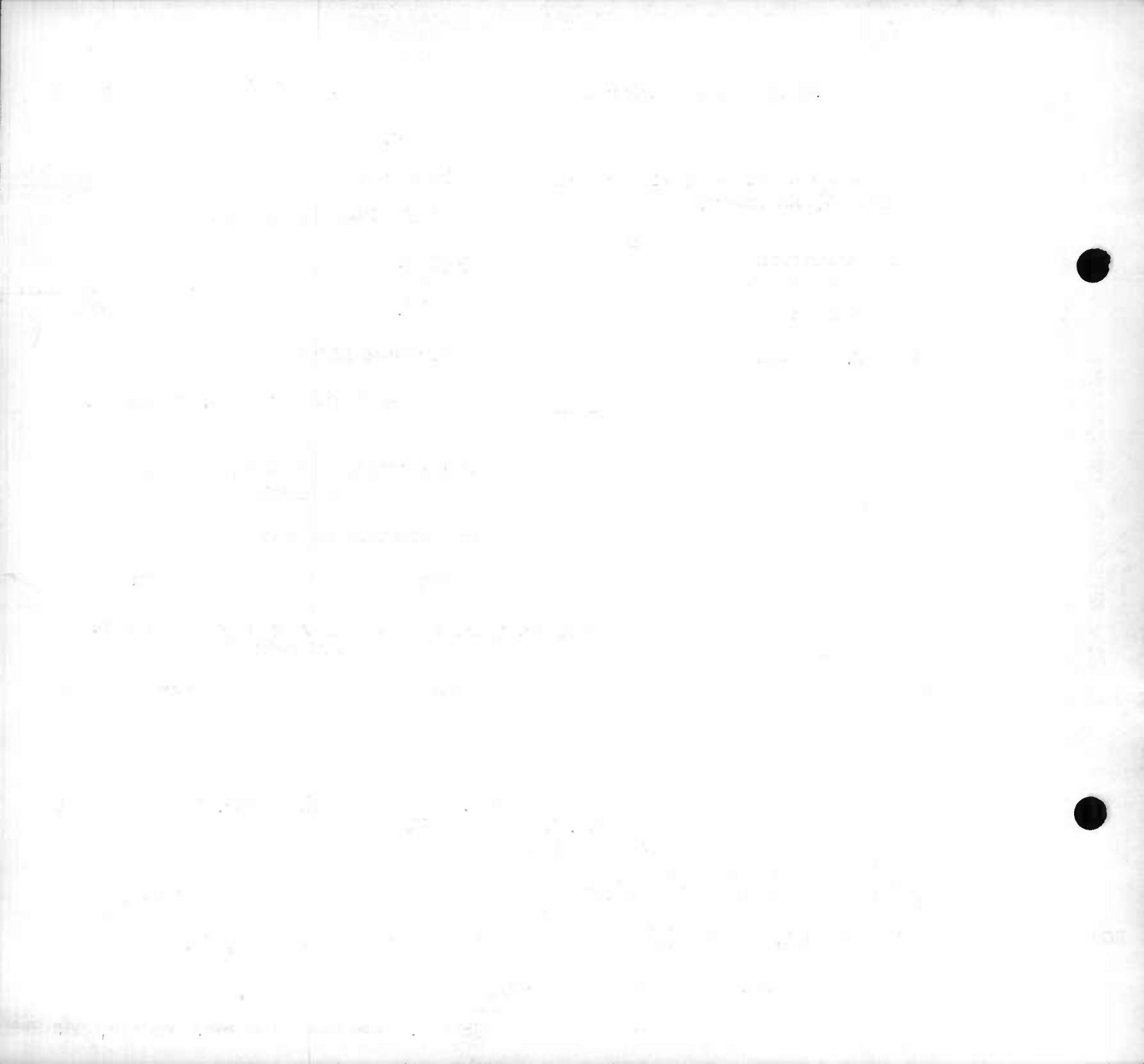
11310



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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B-563 71 11311		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11311	
1. NAME OF DECEASED (Type or Print) Ethel Randall Bomhardt				2. DATE AND HOUR OF DEATH Dec. 2, 1971 6:12 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2X US Public Health Service Hospital 3100 Wyman Parkway				C. CITY OR TOWN Dundalk Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 7836 Charlesmont Road			
5. SEX F	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/02	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John T. Randall				
14. MOTHER'S MAIDEN NAME Florence Rider			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 217-01-2486B			17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.				
18. 599.0 + 203X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE BRONCHOPNEUMONIA, BILATERAL ANTECEDENT CAUSES GRAM NEGATIVE SEPTICEMIA, URINARY TRACT INFECTION DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II MULTIPLE MYELOMA WITH EXTENSIVE BONY METASTASES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days Unknown 7 mos.			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 9 19 71 to Dec. 2 19 71 that (I) (we) last saw the deceased alive on Dec. 2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert F. Wright, M.D.				23B. DATE SIGNED 12/3/71		23C. PHYSICIAN'S NAME (Type) Robert Wright, SA Surg (R)	
23D. ADDRESS US PHS Hospital, Balto, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 12-6-71		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971	
25B. NAME OF REGISTRAR Robert E. Searcy, R.D.		25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 7922 Wise Ave. Dundalk, Md. 2122			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-560		71 11312		BALTIMORE CITY HEALTH DEPARTMENT		71 11312	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Edith M. Domer</i>				2. DATE AND HOUR OF DEATH <i>Dec. 3, 1971</i> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 125 N. Linwood Avenue Baltimore, Md.</i>				A. STATE <i>Md.</i> B. COUNTY <i>601</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>125 N Linwood Ave</i>			
5. SEX <i>F.</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 21, 1915</i>	9. AGE (in years last birthday) <i>56</i>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleslady</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Edward Heffner</i>				14. MOTHER'S MAIDEN NAME <i>Mary Warren</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-03-4287</i>		17. INFORMANT ADDRESS <i>Walter Domer- 125 N. Linwood Ave.</i>			
18. <i>410.91</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <i>10/26</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/15</i> 19 <i>70</i> to <i>12/3</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>10/26</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. H. Goodman</i>				23B. DATE SIGNED <i>12/6/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>J. H. Goodman M.D.</i>				23D. ADDRESS <i>98 Hyghew Ave Balt Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/6/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenmount Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 7 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, R.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran- 3000 E. Baltimore St. Z 24.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11313
L-132 71 11313 BIRTH NO. 1. NAME OF DECEASED (Type or Print) MARIE P. Loftus		2. DATE AND HOUR OF DEATH 12/5/71 15:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 48		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTO 5300 5. CITY OR TOWN CITY DUNDALK 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 60 Shipway 21222		
5. SEX F	6. RACE W W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/23/10	9. AGE (In years last birthday) 61 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME PETER GREDLEIN		
14. MOTHER'S MAIDEN NAME MARGARET VORNBRAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		
16. SOCIAL SECURITY NO.		17. INFORMANT CHARLES CORNELIUS SHARPNESS 60 SHIPWAY 21222		
18. CAUSE OF DEATH 396.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12/1/71 to 12/5/71 that (I) (we) lost saw the deceased alive on 12/5/71 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE G. C. Samaras MD				23B. DATE SIGNED 12/5/71
23C. PHYSICIAN'S NAME (Type) GEORGE C. SAMARAS MD		23D. ADDRESS MCH		
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 9 Dec 71		24C. NAME OF CEMETERY OR CREMATORY Meadow Rose Mem. Pk.
24D. LOCATION (City, town, or county) (State) Howard Co., MD		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		
25B. NAME OF REGISTRAR James E. Smith, Jr.		25C. FUNERAL DIRECTOR Cherich Funeral Home, Dundalk, MD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

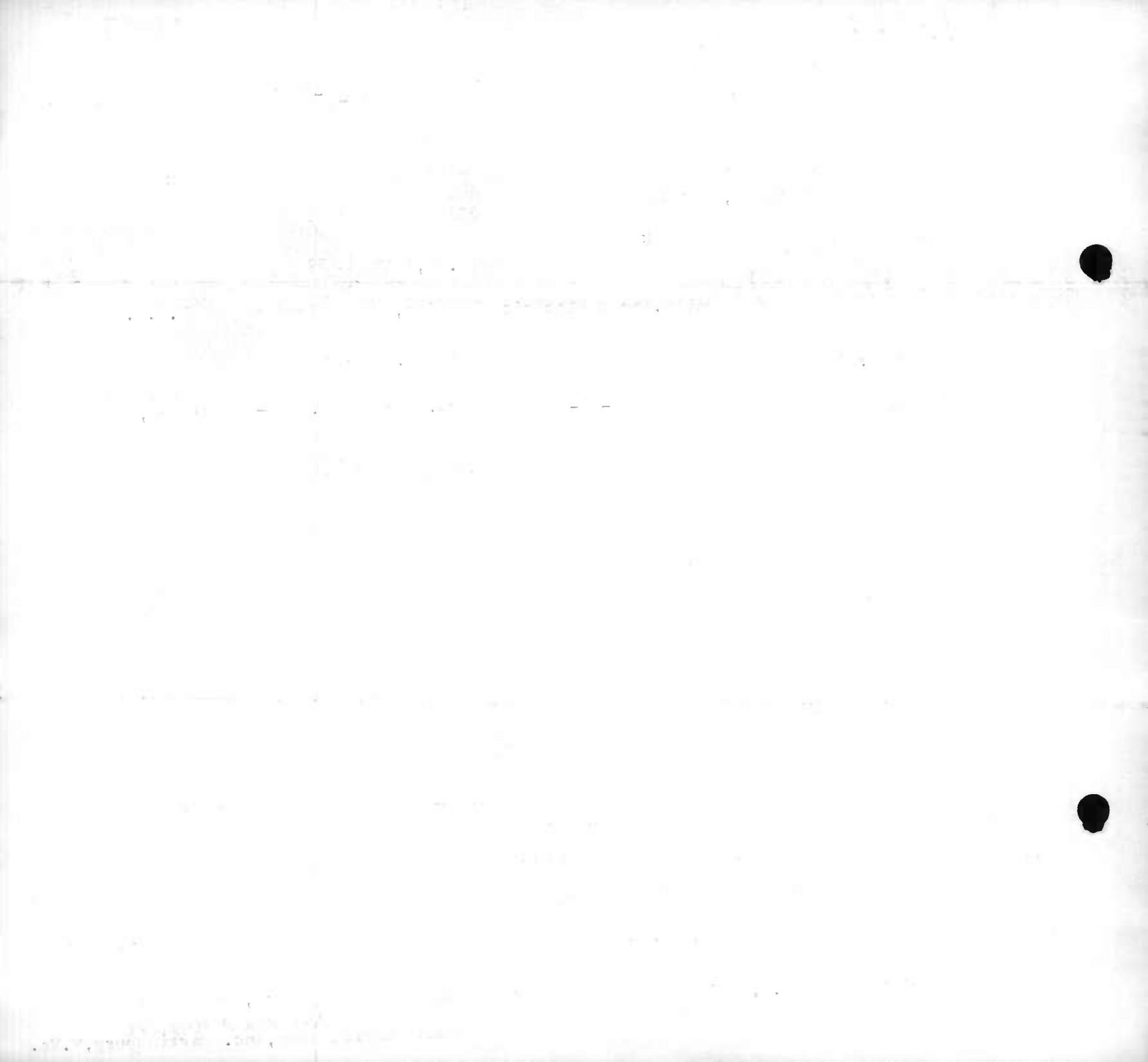
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11314	
R-400 BIRTH NO. 1. NAME OF DECEASED (Type or Print) ADA I. RILEY		71 11314 CERTIFICATE OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 The Wesley Home Inc 2211 W Rogers Avenue		2. DATE AND HOUR OF DEATH December 3 1971 6 P M. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2755 5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2211 West Rogers Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-84	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin F. Davis			
14. MOTHER'S MAIDEN NAME Georgianna Porter		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No			
16. SOCIAL SECURITY NO. 705 07 2364D		17. INFORMANT The Wesley Home Inc 2211 W Rogers Avenue			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 (A) IMMEDIATE CAUSE <u>Cerebral Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>15 October</u> 19 <u>71</u> to <u>3 December</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>3 December</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date <u>3 December</u> 19 <u>71</u> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John W. Barnaby</u> 23C. PHYSICIAN'S NAME (Type) Dr. John W. Barnaby				23B. DATE SIGNED <u>6 Dec 71</u>	
23D. ADDRESS 1652 West Belvedere Avenue				23E. FUNERAL DIRECTOR Burgee Funeral Home, Baltimore Maryland By: <u>Walter Burgee Jr</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. ADDRESS Burgee Funeral Home, Baltimore Maryland			
DEC 7 1971					

7/63 - Adm.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

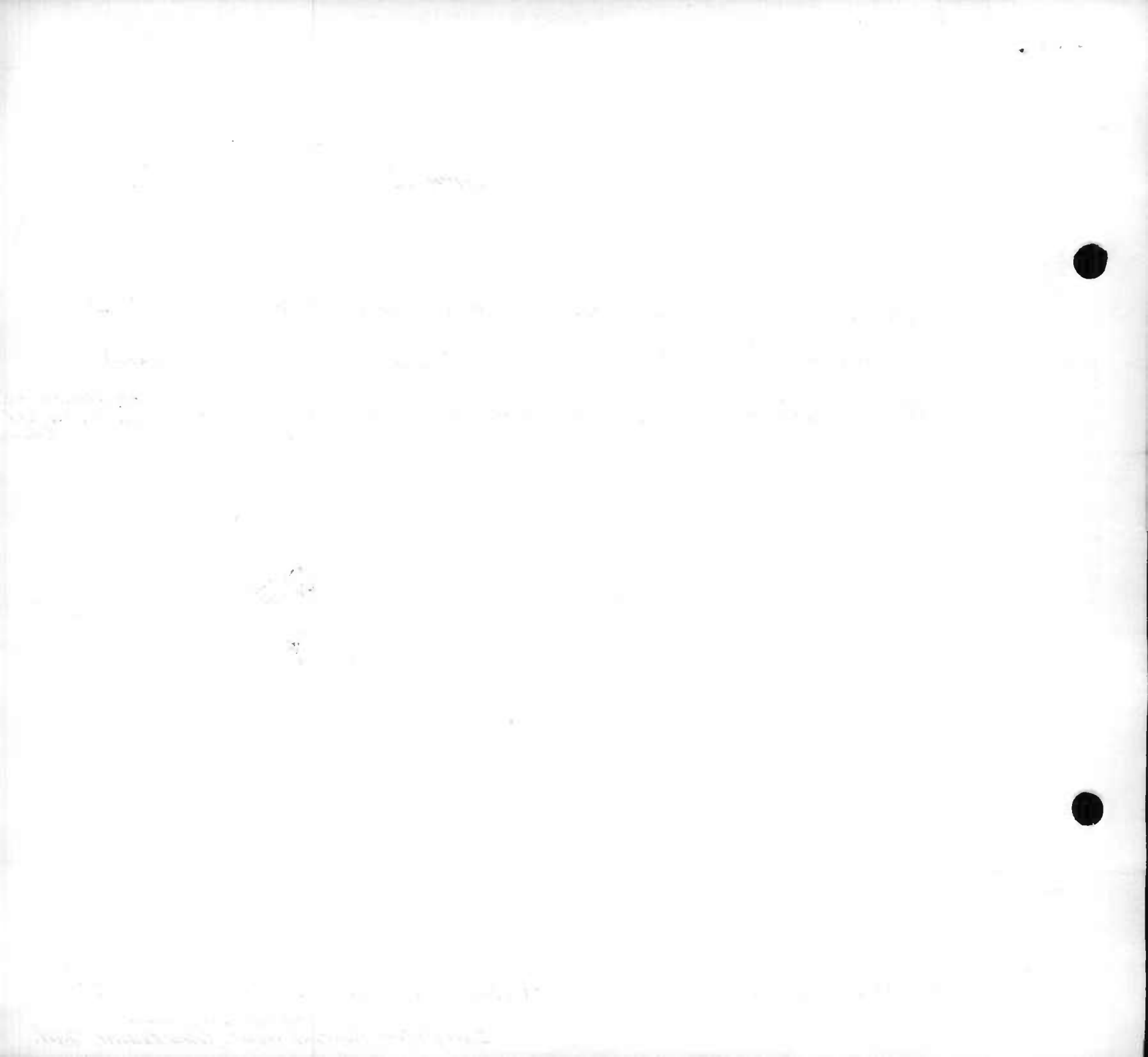
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11315	
BIRTH NO. L-500 71 11315		1. NAME OF DECEASED (Wilbert Carlton Lane) <i>Wilbur Lane</i>		2. DATE AND HOUR OF DEATH 12-1-1971 <i>5:55 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospitals Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 626 Tolna Street			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1912	9. AGE (in years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Electric		11. BIRTHPLACE (State or foreign country) Dobbins, West Virginia	
13. FATHER'S NAME John W. Lane		14. MOTHER'S MAIDEN NAME Beulah V. Coffman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 234-01-6796		17. INFORMANT ADDRESS Mrs. Dorothy E. Lane- 626 Tolna Street Baltimore, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.44250.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Diabetes		5 years.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-17-69 19 to 11-17-71 19 that (I) (we) last saw the deceased alive on 11-17-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sheldon Goldgeier</i>				23B. DATE SIGNED Dec 4, 1971	
23C. PHYSICIAN'S NAME (Type) Sheldon Goldgeier, M.D.		23D. ADDRESS 848 West 36th street Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 4, 1971		24C. NAME of CEMETERY or CREMATORY Rosedale Cemetery Company	
24D. LOCATION (City, town, or county) (State) Martinsburg, West Virginia		25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971			
25B. NAME OF REGISTRAR <i>Robert E. Taber, MD</i>		25C. FUNERAL DIRECTOR <i>Howard K. Brown</i> Brown Funeral Home, Inc. Martinsburg, W. Va.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

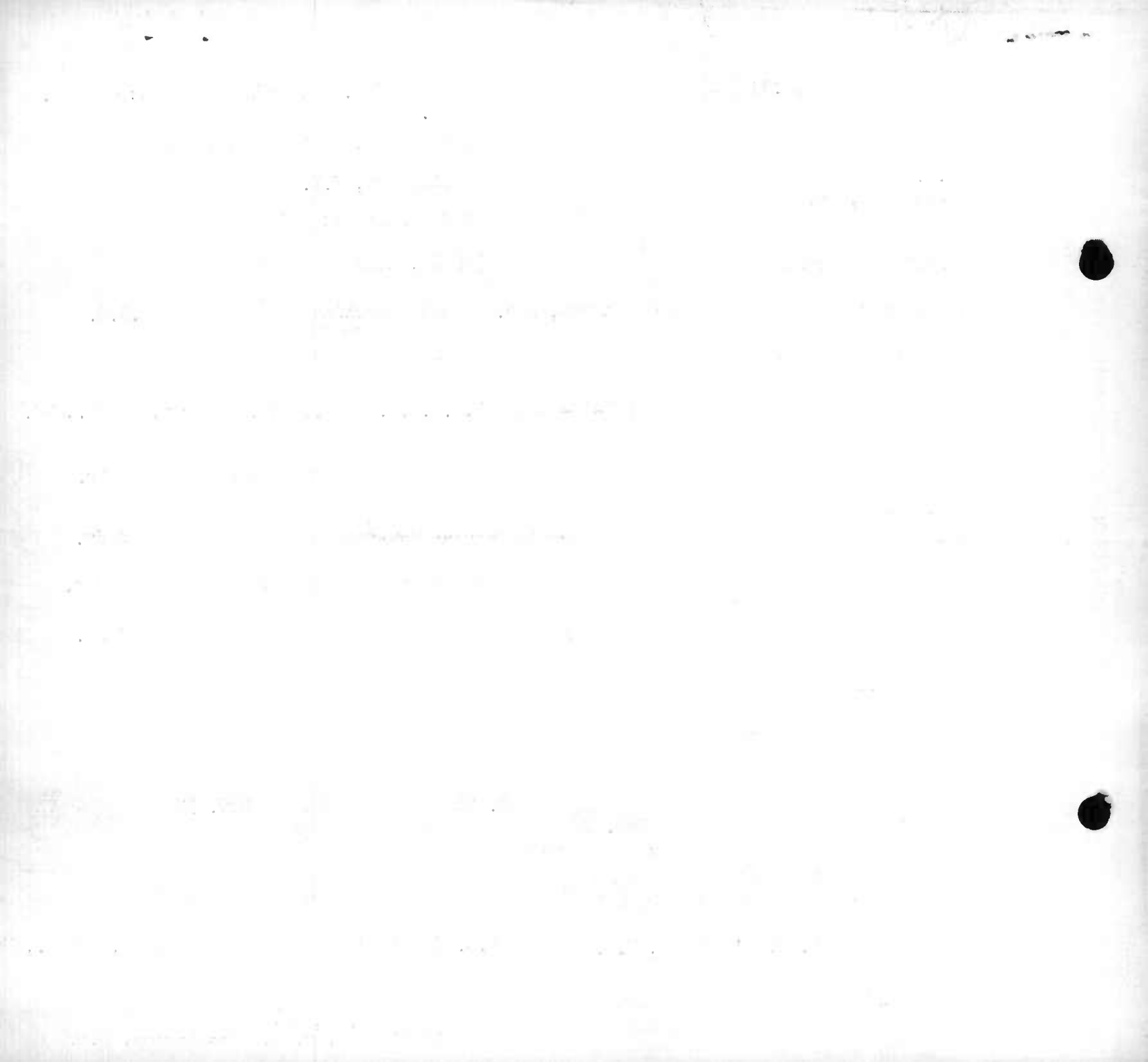
B-622		71 11316		BALTIMORE CITY HEALTH DEPARTMENT		71 11316	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Emma A. Burgess</u>				2. DATE AND HOUR OF DEATH <u>12/5/71</u> <u>11:30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Maryland</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD.</u>		B. COUNTY <u>Anne Arundel</u>	
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-23-96</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		9. AGE (in years last birthday) <u>75</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>(Unknown)</u>				14. MOTHER'S MAIDEN NAME <u>Sophie (Unknown)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-2569D</u>		17. INFORMANT <u>Mrs. Clara D. Gilley (Daughter)</u>		ADDRESS <u>38 Milton Ave. Annapolis, Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>581X I</u> [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Respiratory Distress</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>CVA, CHF</u> (C) <u>Chronic nephrosis</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Since adm. 10 days</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/25</u> 19 <u>71</u> to <u>12/5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>12/5</u> 19 <u>71</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> M.D.				23B. DATE SIGNED <u>12/5/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Young Souk Kim, M.D.</u>				23D. ADDRESS <u>Lutheran Hosp. of Maryland</u>			
24A. BURIAL CREMATION, REMOVAL, (Specify)		24B. DATE <u>12/9/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Barber, R.D.</u>		25C. FUNERAL DIRECTOR <u>Singleton Funeral Home, Glen Burnie, Md.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										REG. NO. <u>71-11347</u>
<div style="display: flex; justify-content: space-between;"> D-60071 11317 </div>										
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Derry, Eli (--)</u>					2. DATE AND HOUR OF DEATH <u>Nov. 30, 1971</u> <u>7:30</u> <u>A.</u> <u>M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>U.S. Public Health Service Hospital</u> <u>Baltimore, Md.</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Washington, District of Columbia</u> <u>V48</u> B. COUNTY 5. CITY OR TOWN <u>Washington, N.E.</u> 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER <u>2946 Mills Ave</u>					
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1913</u>		9. AGE (In years last birthday) <u>58</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Loader</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Safeway Stores, Inc.</u>			11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>McClellan Derry</u>					14. MOTHER'S MAIDEN NAME <u>Minnie Greene</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>252-07-8159</u>		17. INFORMANT <u>U.S.P.H.S. Hosp., Med. Records, Balto., Md.</u> ADDRESS			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>205.01</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Jaundice</u> </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>Congestive Heart Failure</u> <u>1 hr.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute Tubular Necrosis</u> <u>4 da.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Acute Myelo Monocytic Leukemia</u> <u>6 wks.</u> </div> </div>										



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-330 71 11318		BALTIMORE CITY HEALTH DEPARTMENT		71 11318	
BIRTH NO. Martin Henry Stout		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>STOUT, MARTIN</i> Henry		2. DATE AND HOUR OF DEATH <i>12-2-71</i> <i>2:15 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2759</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>4405 Marble Hall Rd.</i>			
5. SEX <i>M</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/18/1894</i>	9. AGE (in years last birthday) <i>77</i>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>B. & O. Rail Road</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Stout</i>			
14. MOTHER'S MAIDEN NAME <i>Anna Danz</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW 1</i>			
16. SOCIAL SECURITY NO. <i>705-05-3149</i>		17. INFORMANT ADDRESS <i>Mrs. Marie Stout same</i>			
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>A.S.C.V.D.</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio respiratory arrest</i> (B) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Myocardial infarction</i> <i>II</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>13 days</i> <i>7</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-18</i> 19 <i>71</i> to <i>12-2</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>12-2</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward S. Remo</i>		23B. DATE SIGNED <i>12-2-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Edward S. Remo, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/4/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cem.</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 7 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Ba lto. Md.</i>		25D. ADDRESS			

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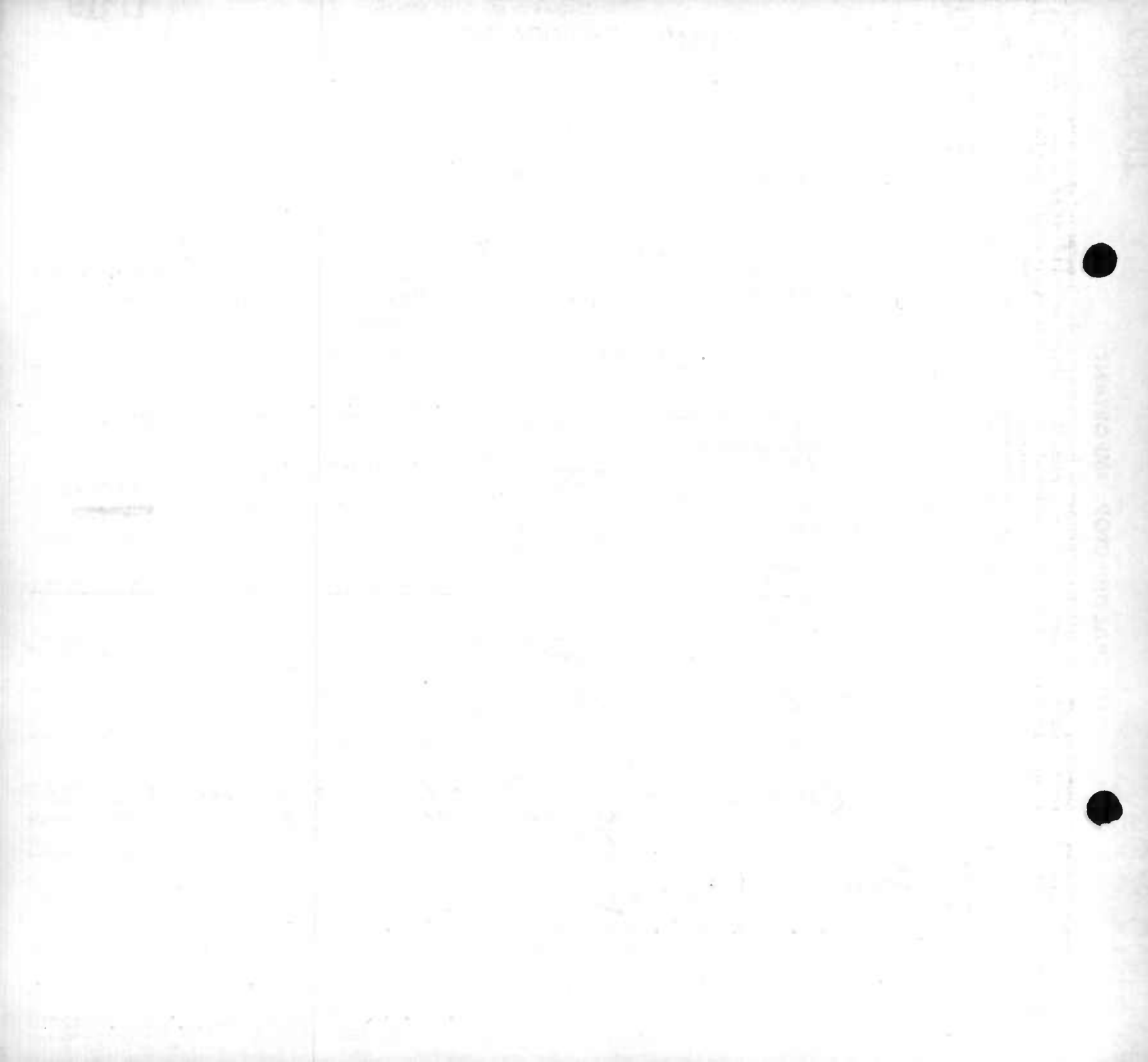
Very Respectfully,
J. B. Jones

Wm. B. Jones

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 11319		71 11319	
BIRTH NO.		71 11319		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		Cora D. O'Hare		2. DATE AND HOUR OF DEATH Dec. 3, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland		B. COUNTY 1203	
FULL NAME OF HOSPITAL OR INSTITUTION 100 2829 Guilford Avenue		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2829 Guilford Ave.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-1893	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William M. Stewart		14. MOTHER'S MAIDEN NAME Cora Dehmeling	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Joseph B. Kelly 2829 Guilford Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Emphysema (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30445 54 YEARS 54 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from OCT 19 1971 to DEC 3 1971 that (1) (we) last saw the deceased alive on NOV 24 1971 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis X. Carmody		23B. DATE SIGNED 12-6-71		23C. PHYSICIAN'S NAME (Type) Dr. Francis X. Carmody	
23D. ADDRESS 3201 N. Charles Street		23E. MED. DIRECTOR Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23F. ADDRESS H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. DEC 7 1971		24F. NAME OF REGISTRAR Robert E. Taylor, Jr.	
24G. NAME OF REGISTRAR		24H. NAME OF REGISTRAR		24I. NAME OF REGISTRAR	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

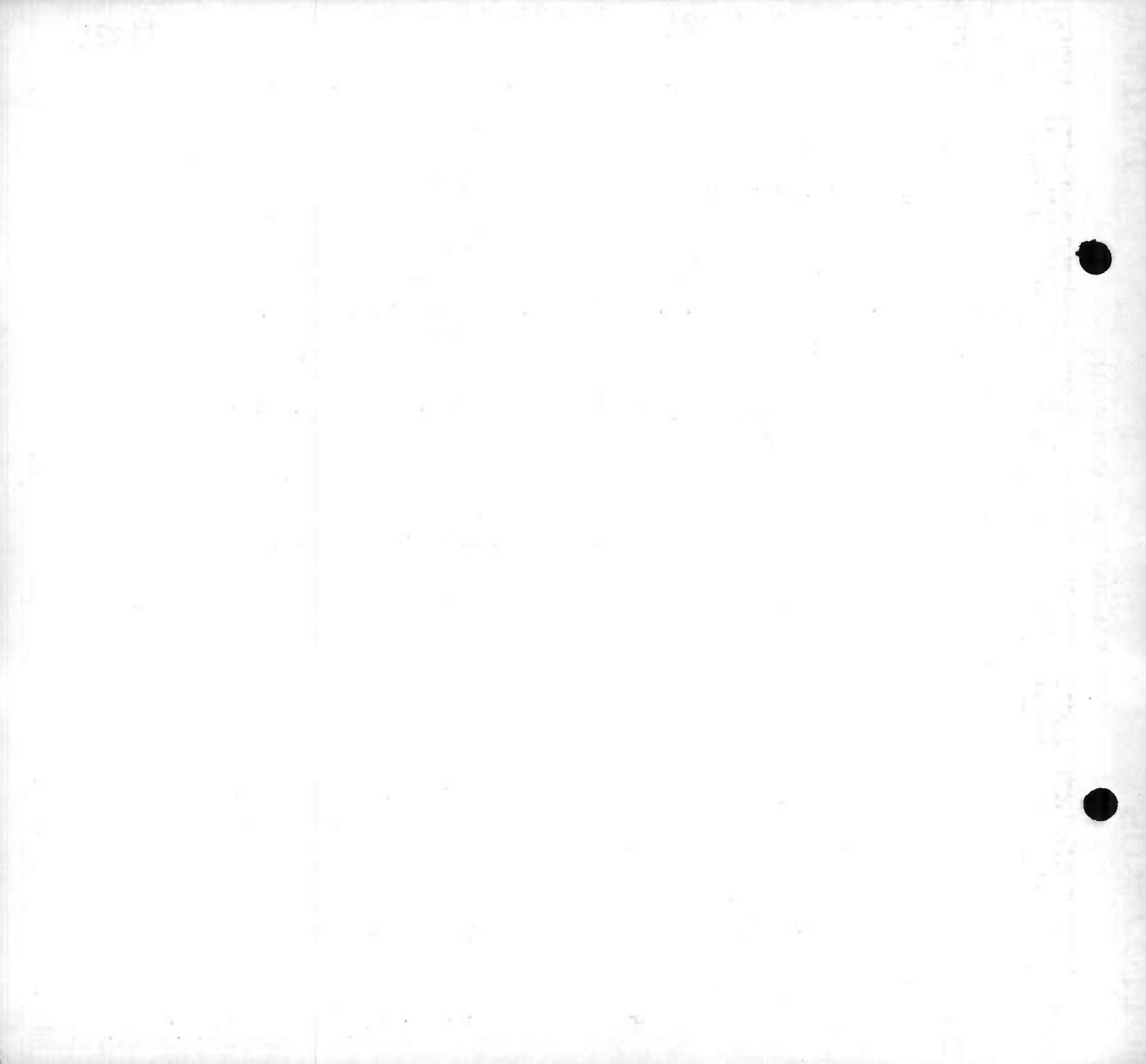
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11320</u>
CERTIFICATE OF DEATH				
N-430 11320				
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Dorothy M. Nalty</u>		December 5, 1971 2:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1202</u>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>340 E. University Pkwy.</u>		
5. SEX <u>F</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-08-87</u>	9. AGE (In years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Tivels</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Flaherty</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>216-05-9164</u>		17. INFORMANT <u>Robert E. Tivels - 22 Phil Drive</u>		
18. CAUSE OF DEATH		ADDRESS <u>N. 27th St. 10596</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Adeno Carcinoma of Esophagus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>- 8 months</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ASCVD</u>		<u>- years</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>November 19 1971</u> to <u>December 5 1971</u> and that (1) (my) last saw the deceased alive on <u>December 5 1971</u> and that (1) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Richard C. Keown MD</u>		23B. DATE SIGNED <u>12/5/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Richard C. Keown MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-10-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Tivels MD</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		
25D. ADDRESS <u>1905 York Road Balto., Md. 21212</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

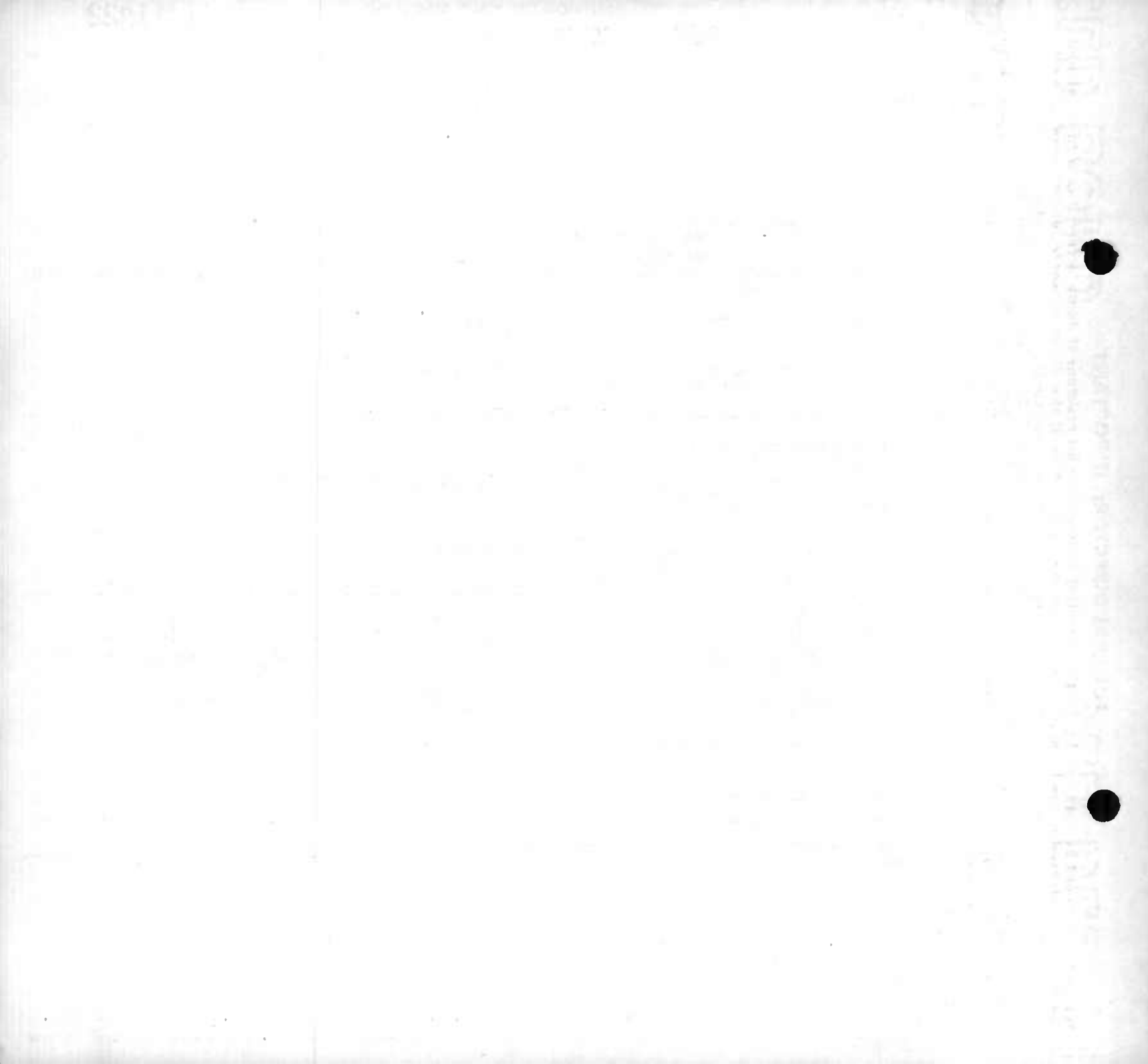
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11321</u>	
<div style="display: flex; justify-content: space-between;"> <u>8-530</u> <u>71 11321</u> CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joseph T. Sinnott, Sr.		Dec. 4, 1971 730 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90</u> Long Green Nursing Home			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1609 Lochwood Road 21218		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1898	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd.		10B. KIND OF BUSINESS OR INDUSTRY L.S. Welding Co.		11. BIRTHPLACE (State or foreign country) Westminister, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Sinnott		14. MOTHER'S MAIDEN NAME Addie M. Delphy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 213-10-4323		17. INFORMANT Mrs. Joseph T. Sinnott	
				ADDRESS Same	
18. <u>412.41</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Broncho-Pneumonia</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Ch. Obstructive lung disease</u>		
			(C) <u>A.S.C. V.D.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 23</u> 19 <u>71</u> to <u>Dec 4</u> 19 <u>71</u> that (I) (last) last saw the deceased alive on <u>Dec 3</u> 19 <u>71</u> and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. William Helfrich</u>		23B. DATE SIGNED <u>6 Dec 71</u>			
23C. PHYSICIAN'S NAME (Type) Dr. William Helfrich		23D. ADDRESS 5006 Roland Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-71		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION Parkville,		(City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 7 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>P-534 71 11322</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p>		<p>CERTIFICATE OF DEATH 71 11322</p>	
<p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print)</p>		<p>2. DATE AND HOUR OF DEATH</p>	
		<p style="text-align: center;">Ella Loretta Pindell</p>		<p style="text-align: center;">12-6-71 2:45 A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY</p>		<p>5. AGE (In years last birthday)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION</p>		<p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p>		<p>C. CITY OR TOWN D. INSIDE CITY LIMITS?</p>	
<p>90 Edgewood Nursing Home</p>		<p>Md. BALTO 5300</p>		<p>Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
		<p>E. STREET AND NUMBER</p>		<p>1009 Halstead Rd.</p>	
<p>5. SEX</p>	<p>6. RACE</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p>	<p>9. AGE (In years last birthday)</p>	<p>10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.</p>
<p>F W</p>	<p>W</p>		<p>12-11-90</p>	<p>80</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country)</p>	
<p>Housewife</p>		<p>Own Home</p>		<p>Balto., Md. USA</p>	
<p>13. FATHER'S NAME</p>		<p>14. MOTHER'S MAIDEN NAME</p>			
<p>Peter McMahon</p>		<p>Ellen Coughlin</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS</p>	
<p>No</p>		<p>145-09-1660-B</p>		<p>Ray A. Pindell Same</p>	
<p>18. 437.94250.9</p>		<p>CAUSE OF DEATH</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>3 mos</p>	
<p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p>		<p><i>Coronary arteriosclerosis</i></p>			
<p>ANTECEDENT CAUSES</p>		<p>(B) <i>Generalized arteriosclerosis</i></p>		<p>? yrs</p>	
<p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(C)</p>			
<p>II</p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p><i>Diabetes mellitus</i> 3+ mos.</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>0 Sept 1971</p>		<p><i>Impacted tooth - gangrene</i></p>		<p>no</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate by marking box)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p><input type="checkbox"/></p>					
<p>21D. TIME OF INJURY (APPROX.)</p>		<p>21E. INJURY OCCURRED</p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>(Month) (Day) (Year) (Hour)</p>		<p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <u>10-18</u> 19<u>71</u> to <u>12-6</u> 19<u>71</u> that (I) (we) last saw the deceased alive on <u>12-5</u> 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE</p>		<p>23B. DATE SIGNED</p>			
<p><i>Frederick J. Vollmer M.D.</i></p>		<p>12-6-71</p>			
<p>23C. PHYSICIAN'S NAME (Type)</p>		<p>23D. ADDRESS</p>			
<p>Dr. Frederick J. Vollmer</p>		<p>6100 York Rd.</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>		<p>24B. DATE</p>		<p>24C. NAME of CEMETERY or CREMATORY</p>	
<p>Entombment</p>		<p>12-9-71</p>		<p>Loudon Park Cemetery</p>	
				<p>Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p>		<p>25B. NAME OF REGISTRAR</p>		<p>25C. FUNERAL DIRECTOR</p>	
<p>DEC 7 1971</p>		<p><i>Robert E. Taylor, M.D.</i></p>		<p>H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212</p>	



CERTIFICATE OF DEATH

REG. NO. **71 11323**BIRTH NO. **08-13716 11323**

1. NAME OF DECEASED

(Type or Print)

Arlen Powell

2. DATE AND HOUR OF DEATH

December 2, 1971**2:50pm.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**31****Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224**

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1525 E. Biddle Street, 21231

5. SEX

Male

6. RACE

Negro7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7-28-689. AGE (In years
last birthday)**3**

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**None**

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William

14. MOTHER'S MAIDEN NAME

Sue15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)**No.**

16. SOCIAL SECURITY NO.

17. INFORMANT

BCH RECORDS:

ADDRESS

**4940 Eastern Avenue
Baltimore, Maryland 21224**18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying,
heart failure, ashenia, etc. It means the disease
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Renal FailureAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**36 hrs**

(B) DUE TO, OR AS A CONSEQUENCE OF:

70% 3° burns**3 days**(C) **House fire**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

None19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
11 29 7121B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)**Home**

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☒21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)**1525 E. Biddle St. 800**

21F. HOW DID INJURY OCCUR?

House fire22. I certify that ☒ (this hospital) attended the deceased from **11/29/71** 19 to **12/2/71** 19
that ☒ (we) lost saw the deceased alive on **12/2/71** 19 and that in ☒ (our) opinion death occurred on the date
and hour and from the causes stated above. ☒ (We) (did) (did not) view the body after death.

23A. SIGNATURE

L. Turnbaugh M.D.Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/2/7123C. PHYSICIAN'S
NAME (Type)**Lois Turnbaugh, M.D.**

23D. ADDRESS

4940 Eastern Avenue**Baltimore, Maryland 21224**24A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

24B. DATE

12-7-71

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION

A. A. County Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 7 1971

25B. NAME OF REGISTRAR

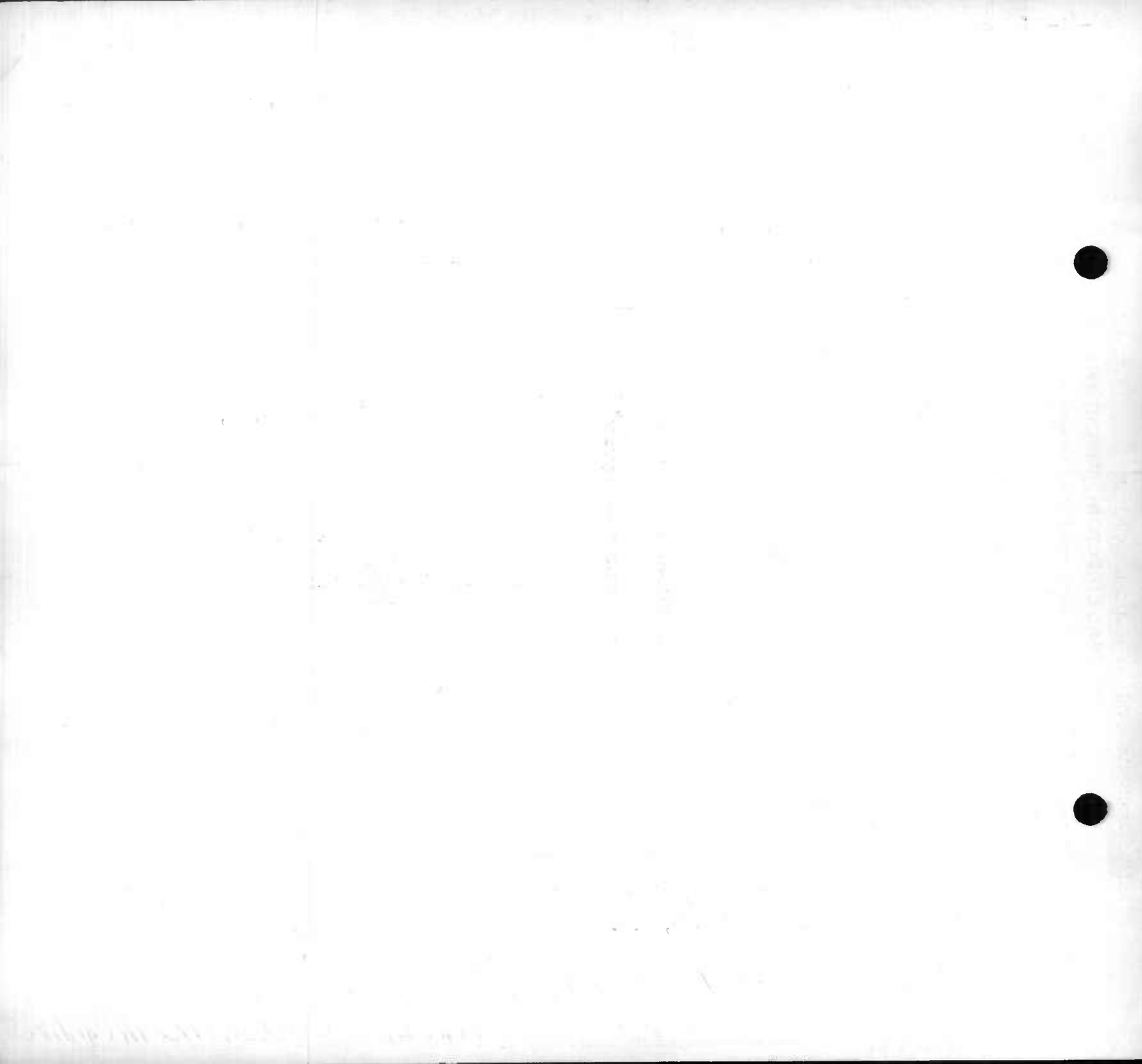
Robert E. Gable, M.D.

25C. FUNERAL DIRECTOR

Milton E. Elchert-1129 N. Cardine St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



71 11324

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11324

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Emma Lunn		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month 12 Day 2 Year 71 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1604 Vincent Court		3. DATE PRONOUNCED DEAD Month 12 Day 4 Year 71 Hour 10:25 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12-10-22		10. AGE (In years lost birth day) 48	
11. BIRTHPLACE (State or foreign country) Darlington S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N/A		17. SOCIAL SECURITY NO. A/A	
18. INFORMANT Mrs. Anna Gross		ADDRESS 2700 Elsinore C - 4	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fatty alteration of liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME OF INJURY (APPROX.) Found: 12-4-71		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? 1604 Vincent Court		22F. HOW DID INJURY OCCUR? Beaten about head	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 12-7-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett Funeral Home		ADDRESS 1701 Laurens St.	

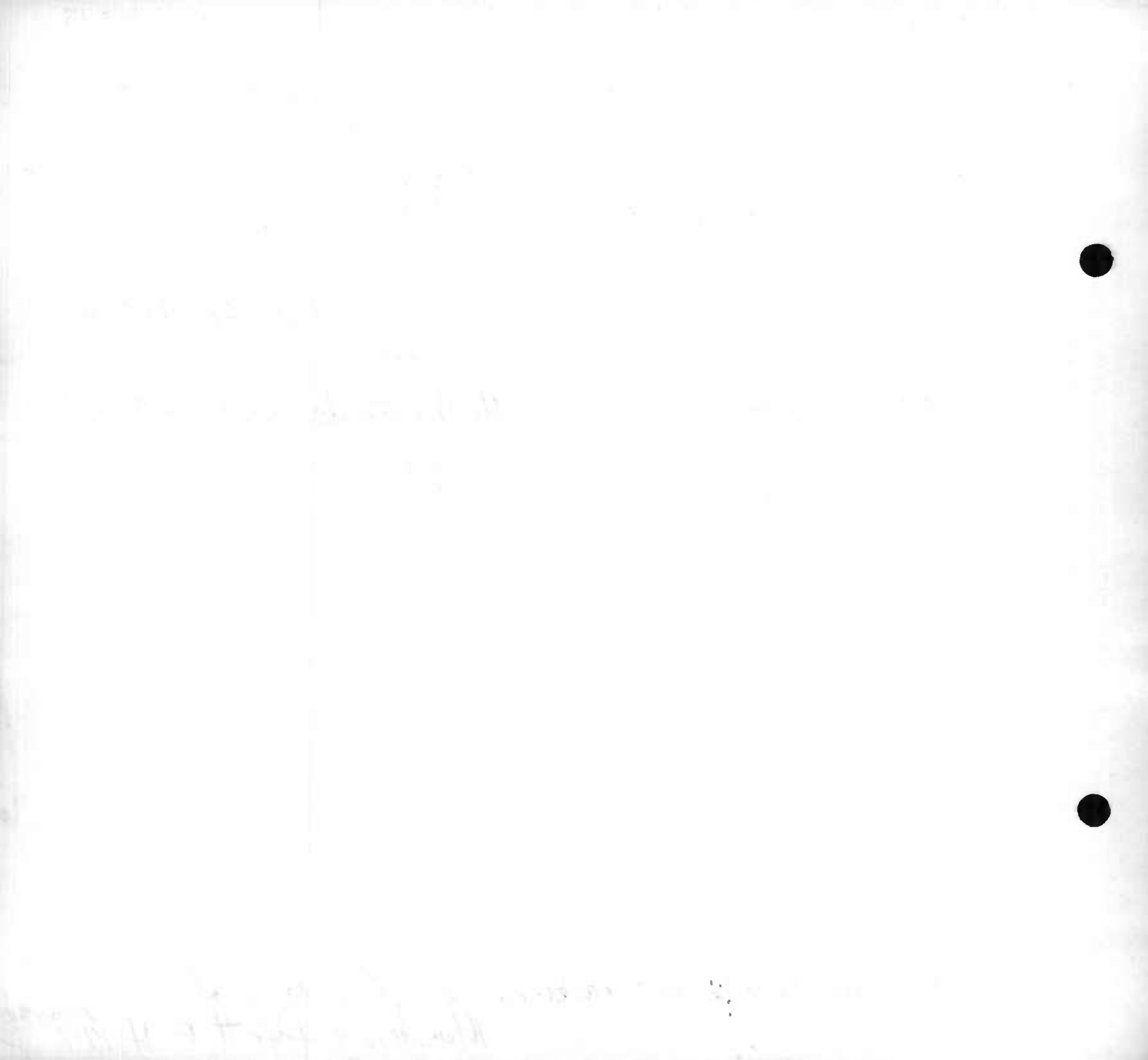
1911

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-300 71 11325		BALTIMORE CITY HEALTH DEPARTMENT		71 11325	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type as Print)		2. DATE AND HOUR OF DEATH			
Scott Anna L.		12/13/71 4:25 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Don Secour Hospital		A. STATE B. COUNTY		2004	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/1/00		9. AGE (in years last birthday) 71		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia, Charlottesville	
13. FATHER'S NAME William Scott		14. MOTHER'S MAIDEN NAME Polly Cole		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Martha Goode - 2153 - Hollins St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.9 I CAUSE OF DEATH		(A) IMMEDIATE CAUSE CVA DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 2, 1971 to Dec. 3, 1971 that (I) (we) last saw the deceased alive on Dec. 3, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bundit H12		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) BANDSTH	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-6-71		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. Bkfst. Mt.	
25A. DATE REC'D BY HEALTH DEPT. DEC 7 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H. 1701 S	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-250 11326		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 11326	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) TYSON, JAMES WILBUR, JR.			2. DATE AND HOUR OF DEATH 12 6 71 2:00P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY AA C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 42 WINDING WOODS WAY		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-1908	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk		10B. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Elec.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James Wilbur Tyson, Sr.		
14. MOTHER'S MAIDEN NAME Edna Meeks			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		
16. SOCIAL SECURITY NO. 212-10-5694			17. INFORMANT Grace Tyson, Same		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 6			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. HOW DID INJURY OCCUR?		
21E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21F. HOW DID INJURY OCCUR?		
21G. WHITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>			21H. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11/1 1960 to 12/6 1971 that (I) (we) last saw the deceased alive on 11/3 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John H Shaw			23B. DATE SIGNED 12/7/71		
23C. PHYSICIAN'S NAME (Type) JOHN H SHAW			23D. ADDRESS 5800 EMMANUEL AVE. UNIT 2100		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-71		24C. NAME OF CEMETERY OR CREMATORY Meadowridge	
24D. LOCATION Dorsey, Md.		24E. DATE REQUIRED BY HEALTH DEPT. DEC 8 1971		24F. NAME OF REGISTRAR Robert E. Barber, M.D.	
24G. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.		24H. ADDRESS		24I. DATE	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11327	
1. NAME OF DECEASED (Type or Print) HARVEY MOYLAN		2. DATE AND HOUR OF DEATH 12-06-71 6 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home and Hospital 100 N. Broadway St. Baltimore MD 21231		A. STATE MD B. COUNTY Baltimore County C. CITY OR TOWN Baltimore County D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3210 Woodhome Ave.	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-17-1904 9. AGE (in years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Taxi Driver Yellow Cab Co.		11. BIRTHPLACE (State or foreign country) Baltimore	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James MOYLAN		14. MOTHER'S MAIDEN NAME Catherine Harvey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-05-7600	
17. INFORMANT A. Found near Church Home Hospital		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Renal Failure Many years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardio Vascular Disease Many years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Old myocardial infarction. Emphysema. Hypertension.			
19A. DATE OF OPERATION None	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None	20A. AUTOPSY? (Yes or No) None 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) None	21E. INJURY OCCURRED None	21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from 11-27-71 to 12-6-71 that (I) (we) last saw the deceased alive on 12-5-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE S.P. George MD		23B. DATE SIGNED 12/6/71	
23C. PHYSICIAN'S NAME (Type) S. P. GEORGE		23D. ADDRESS CHURCH HOME AND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12-9-71	24C. NAME OF CEMETERY OR CREMATORY LONDON PARK CEMETERY	24D. LOCATION (City, town, or county) (State) BALTIMORE MD
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971	25B. NAME OF REGISTRAR John E. Taber, MD	25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC ADDRESS BALTO, MD	

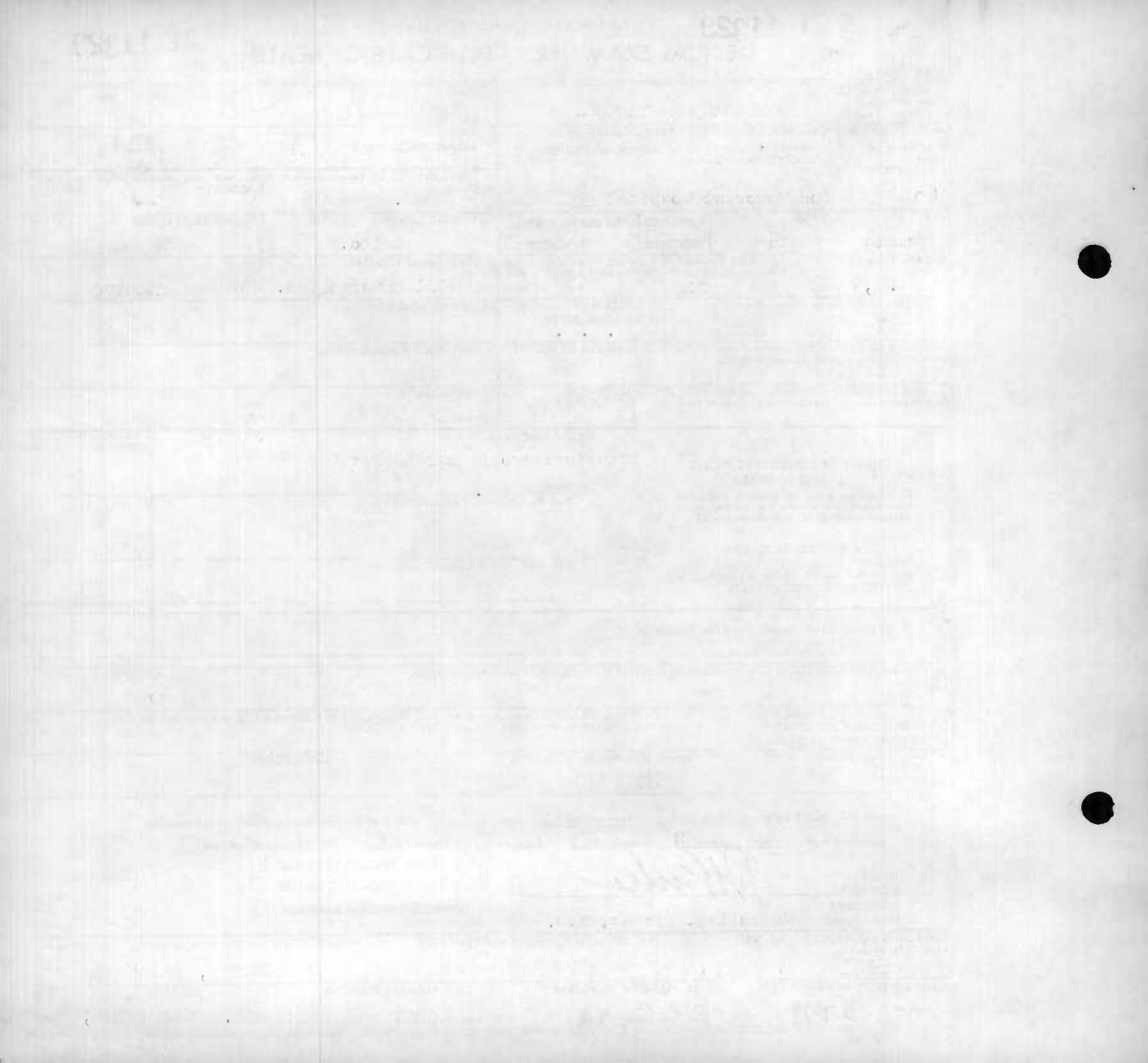


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-520 71 11328		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11328	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BONACCI, SAMUEL F.		2. DATE AND HOUR OF DEATH 12/5/71 11 30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE 12/5/71 B. COUNTY New Jersey, Mercer		C. CITY OR TOWN Trenton, N J D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		E. STREET AND NUMBER 770 Lawrence Road		86638 V27	
5. SEX Male	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/06/12	9. AGE (in years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President Three A Trucking Co		10B. KIND OF BUSINESS OR INDUSTRY Trucking Co		11. BIRTHPLACE (State or foreign country) Penna	
13. FATHER'S NAME Eugene Bonacci		14. MOTHER'S MAIDEN NAME Rose Scarponi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 153-09-2129		17. INFORMANT Mrs Margaret J Bonacci	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial ischemia 2 hr. Pulmonary edema 3 days Pneumonia 5 days		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Abdominal aortic Aneurysm Resected 7 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr. 3 days 5 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 11/29/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABD. AORTIC ANEURYSM		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/25 19 71 to 12/5 19 71 that (I) (we) last saw the deceased alive on 12/5 19 71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Geoffrey M. Graeber M.D.		23B. DATE SIGNED 12/5/71		23C. PHYSICIAN'S NAME (Type) Geoffrey M. Graeber, M.D.	
23D. ADDRESS The Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12/9/71		24C. NAME of CEMETERY or CREMATORY St Mary's		24D. LOCATION (City, town, or county) (State) Trenton, New Jersey	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert J. A. ...		25C. FUNERAL DIRECTOR ADDRESS Leonard J Ryck Inc. Baltimore, Md	

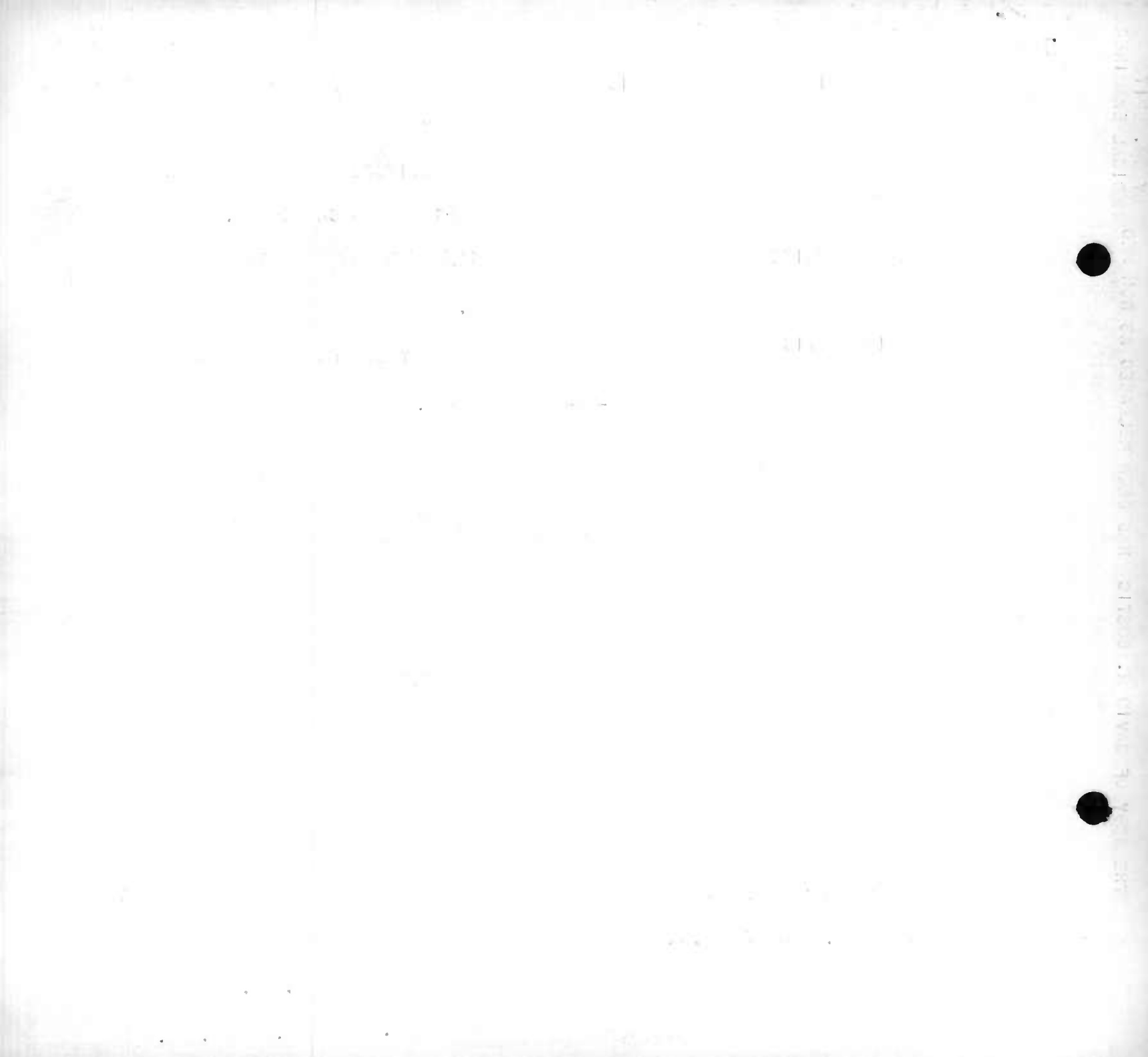




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-23271 11330				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11330	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) DAVID HOUSTON BOSTIC		2. DATE AND HOUR OF DEATH 12/4/71 3:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2714		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial				5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 12/09/53		9. AGE (In years last birthday) 17	
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LEWIS BOSTIC		14. MOTHER'S MAIDEN NAME RUBY CONNER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 220-64-1174		17. INFORMANT Lewis A. Bostic same		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ventricular fibrillation (B) DUE TO, OR AS A CONSEQUENCE OF: Primary Pulmonary Hypertension 3yr (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION				19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE John A. Kiely M.D. DEGREE		23B. DATE SIGNED 12/5/71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) JOHN A. KIELY M.D.				23D. ADDRESS The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/8/71		24C. NAME of CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971				25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR Leonard J. Luck Inc. Balto. Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 11331 REG. NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH	
BIRTH NO. 7-200 1. NAME OF DECEASED (Type or Print) JOHN FICK		2. DATE AND HOUR OF DEATH 12-4-71 3 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2634 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4905 E CHASE STREET	
5. SEX M 6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23 / 80 9. AGE (In years last birthday) 91	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY AMERICAN	
13. FATHER'S NAME Fick		14. MOTHER'S MAIDEN NAME -	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-16-4740	
17. INFORMANT Beulah B. Hornig XXXXXX XXXXXX		ADDRESS 21057 13020 Manor Rd. SAME	
18. 43691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRO VASCULAR ACCIDENT		(B) DUE TO, OR AS A CONSEQUENCE OF: CEREBRO VASCULAR ACCIDENT	
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 12-3-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-23 19 71 to 12-4 19 71 that (I) (we) last saw the deceased alive on 12-3 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Juan M. Calderon		23B. DATE SIGNED 12-4-71	
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON M.D.		23D. ADDRESS U.M.H.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71	
24C. NAME of CEMETERY or CREMATORY Parkwood Cem.		24D. LOCATION (City, town, or county) (State) Balto. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-623 71 11332		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 11332	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LAURA BRIGHT		2. DATE AND HOUR OF DEATH 11-30-71 245 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY HOWARD		6.300	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		C. CITY OR TOWN DAYTON		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		5. SEX F		6. RACE N	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-35		9. AGE (in years last birthday) 36	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME Phillip Bright		14. MOTHER'S MAIDEN NAME Stella Clark	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Hemorrhagic Shock (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic Ca of Rectum & upper vagina Ca of the Cervix		CAUSE OF DEATH Rectovaginal fistula		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 4-2-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of the Cervix	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-29- 19 71 to 11-30- 19 71 that (I) (we) last saw the deceased alive on 11-30- 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nathaniel Atkins-Afful, M.D. DEGREE				23B. DATE SIGNED 11-30-71	
23C. PHYSICIAN'S NAME (Type) NATHANIEL ATKINS-AFFUL, M.D. DEGREE				23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-4-71		24C. NAME OF CEMETERY OR CREMATORY HOPKINS CEMETERY	
24D. LOCATION (City, town, or county) (State) Highland, HOWARD MD.		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR George R. Snowden	
25C. FUNERAL DIRECTOR Rockville		25D. ADDRESS			

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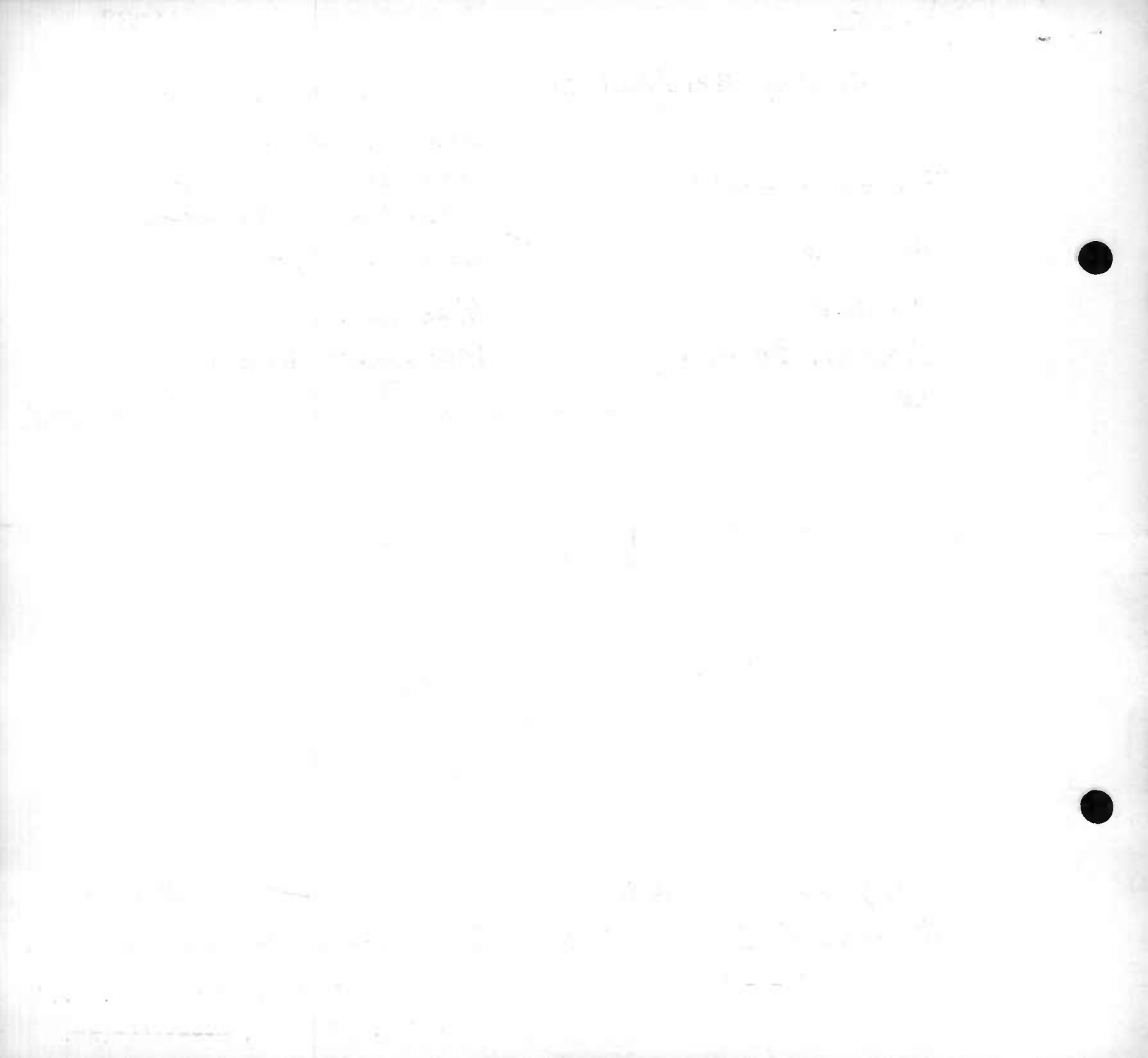
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

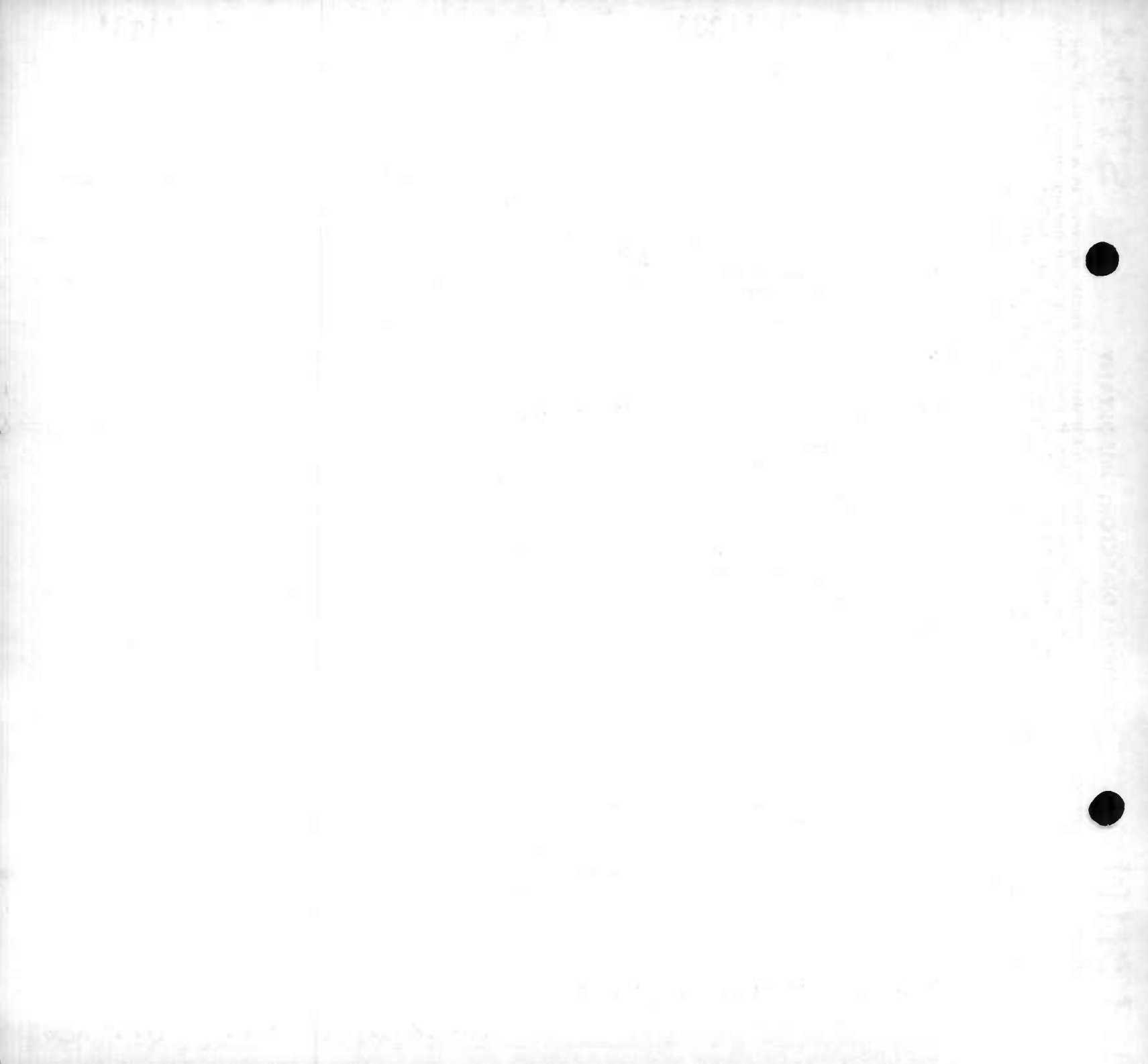
BALTIMORE CITY HEALTH DEPARTMENT				71 11333		REG. NO. 71 11333	
BIRTH NO. B-452		71 11333		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Bowling, Bradford C.				2. DATE AND HOUR OF DEATH 11/29/71 11:35 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Rockville, Maryland		B. COUNTY Montgomery	
				C. CITY OR TOWN Rockville		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1607 Gruenther Ave			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 02/01/54		9. AGE (in years last birthday) 17	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Bowling				14. MOTHER'S MAIDEN NAME MARGARET Reber			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph L. Bowling		ADDRESS 1607 Gruenther Ave, Rockville Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardio-respiratory arrest				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Metastatic Carcinoma of colon DUE TO, OR AS A CONSEQUENCE OF:			
				(C) —			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 20/11/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Clostridial infection		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov 1 19 71 to Nov 29 19 71 that (I) (we) last saw the deceased alive on Nov 29 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael J. Zinner M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/29/71	
23C. PHYSICIAN'S NAME (Type) MICHAEL J. Zinner M.D.				23D. ADDRESS Johns Hopkins Hospital Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12-4-71		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Suitland, Prince Geo. Co., MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ROBERT A. RUMPHREY, ROCKVILLE, MD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

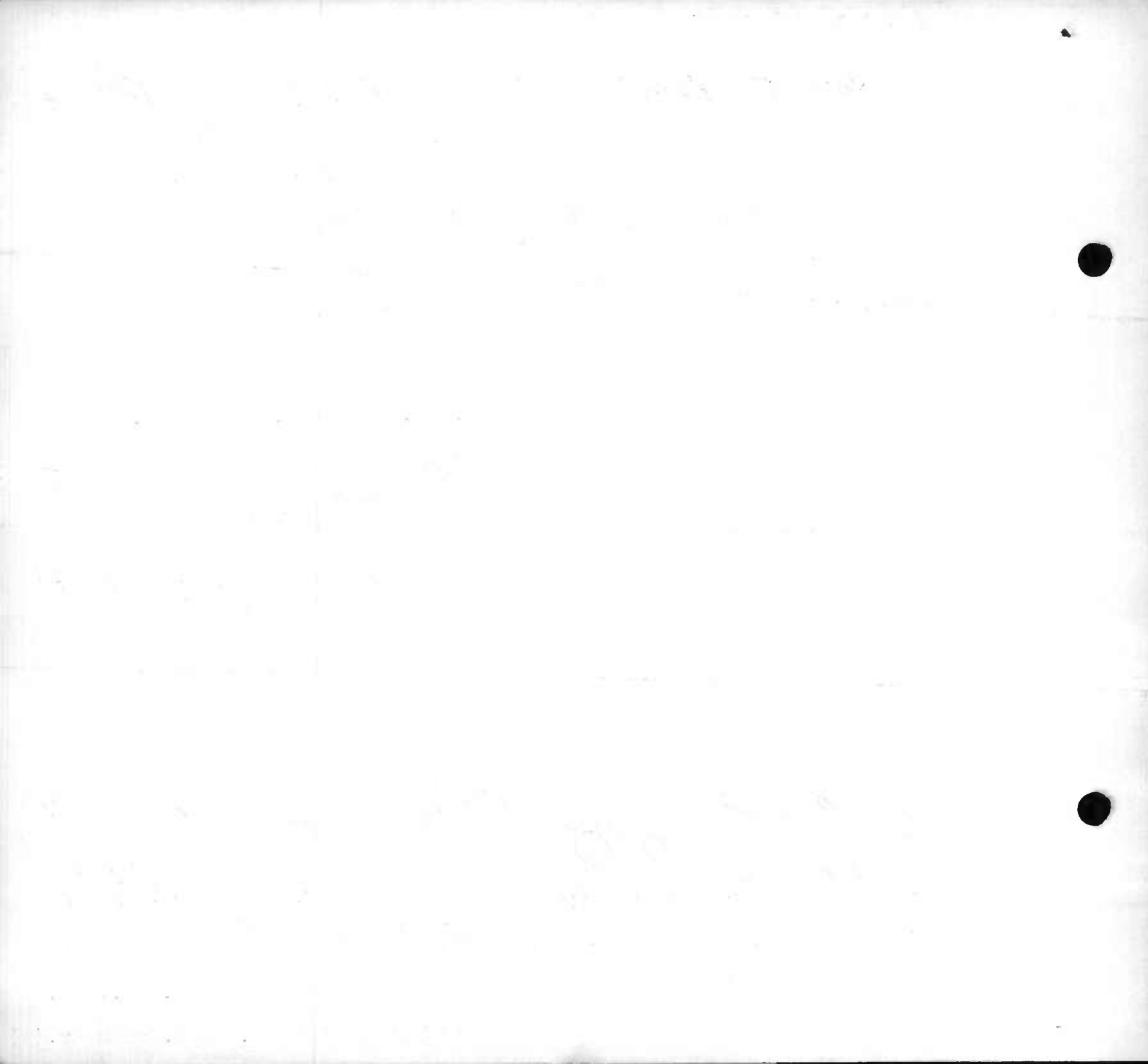
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11334	
BIRTH NO. R-340 71 11334					
1. NAME OF DECEASED (Type or Print) EVA M. RIDDLE			2. DATE AND HOUR OF DEATH Dec 6, 1971 1-25 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5 Church Home & Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Baltimore Maryland B. COUNTY 5300		
			C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 314 Magnolia Terrace		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/27/93	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Wm. Rhoads		14. MOTHER'S MAIDEN NAME Martha Markle		12. CITIZEN OF WHAT COUNTRY? US	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 180-22-1957		17. INFORMANT Ether Beers ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4-3/1017-250.9 CAUSE OF DEATH CVA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: intracerebral hemorrhage with subarachnoid extension (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C) Stroke ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, 10y 25y			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH less Than 2 hrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/4 19 71 to 12/6 19 71 that (I) (we) last saw the deceased alive on 12/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gemma P. Indolos				23B. DATE SIGNED Dec	
23C. PHYSICIAN'S NAME (Type) GENMA P. INDOLOS, M.D.				23D. ADDRESS Church Home & Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 12/9/71		24C. NAME OF CEMETERY OR CREMATORY UNION	
24D. LOCATION WEATHERLY PA.		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971			
25B. NAME OF REGISTRAR Reese		25C. FUNERAL DIRECTOR J.G. CONNELLY SONS ADDRESS 300 MACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-500 71 11335		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11335	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MON TOY HOM (TOM DRY)		2. DATE AND HOUR OF DEATH 12/6/71 1:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 91 MONTEBELLO STATE HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE ORIENTAL		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDERER		10B. KIND OF BUSINESS OR INDUSTRY LAUNDRY		8. DATE OF BIRTH ?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		9. AGE (In years last birthday) 84	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) CHINA	
17. INFORMANT Friend: Mr. Jas. Wu 2430 N. Charles St. 21218		12. CITIZEN OF WHAT COUNTRY? U.S. ?		18. CAUSE OF DEATH ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years (+)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examined)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from 7/29/69 19 71 to 12/6 19 71 that (I) (we) last saw the deceased alive on 12/6 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Joseph Kenneth Marshall, Jr. M.D.		23B. DATE SIGNED 12/6/71		23C. PHYSICIAN'S NAME (Type) JOSEPH KENNETH MARSHALL, JR. M.D.	
23D. ADDRESS Montebello State Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/71	
24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971	
25B. NAME OF REGISTRAR Charles E. Taylor, M.D.		25C. FUNERAL DIRECTOR STEWART & MOWEN CO.		25D. ADDRESS 108 W. North Av. (1)	



FUNERAL DIRECTOR: IMPORTANT

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N-550 71 11336		BALTIMORE CITY HEALTH DEPARTMENT		71 11336	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		NEWMAN, HARRY R		2. DATE AND HOUR OF DEATH DECEMBER 6, 1971 11:55A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		5300	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		MARYLAND BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. (INSIDE CITY LIMITS?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 13 Second Ave			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/05/89	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED POLICEMAN		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) TENNESSEE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN NEWMAN		14. MOTHER'S MAIDEN NAME JULIA JACKSON NEWMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 212-07-0238		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OF ALL MAJOR CORONARIES Posterosseptal myocardial infarction Recent about 4-5 days old		CAUSE OF DEATH Atherosclerotic coronary artery disease of all major coronaries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Posterosseptal myocardial infarction Recent about 4-5 days old		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 01 1971 to DECEMBER 06 1971 that (I) (we) last saw the deceased alive on DECEMBER 06 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Perfecto Valarao		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/6/71	
23C. PHYSICIAN'S NAME (Type) PERFECTO VALARAO, M.D.		23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/71		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	
24D. LOCATION Woodlawn Md.		24E. NAME OF REGISTRAR John E. Fisher, R.D.		24F. NAME OF FUNERAL DIRECTOR John J. Cowan & Son Inc.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR		25C. NAME OF FUNERAL DIRECTOR	
25D. ADDRESS 23. Md.					

STATION

ST. LOUIS

ST. LOUIS

WHITE

ST. LOUIS

"A.S."

TENNESSEE

ST. LOUIS RAILROAD

JULIA JACKSON

ST. LOUIS

ST. LOUIS RAILROAD

DECEMBER 21

DECEMBER 21

DECEMBER 21

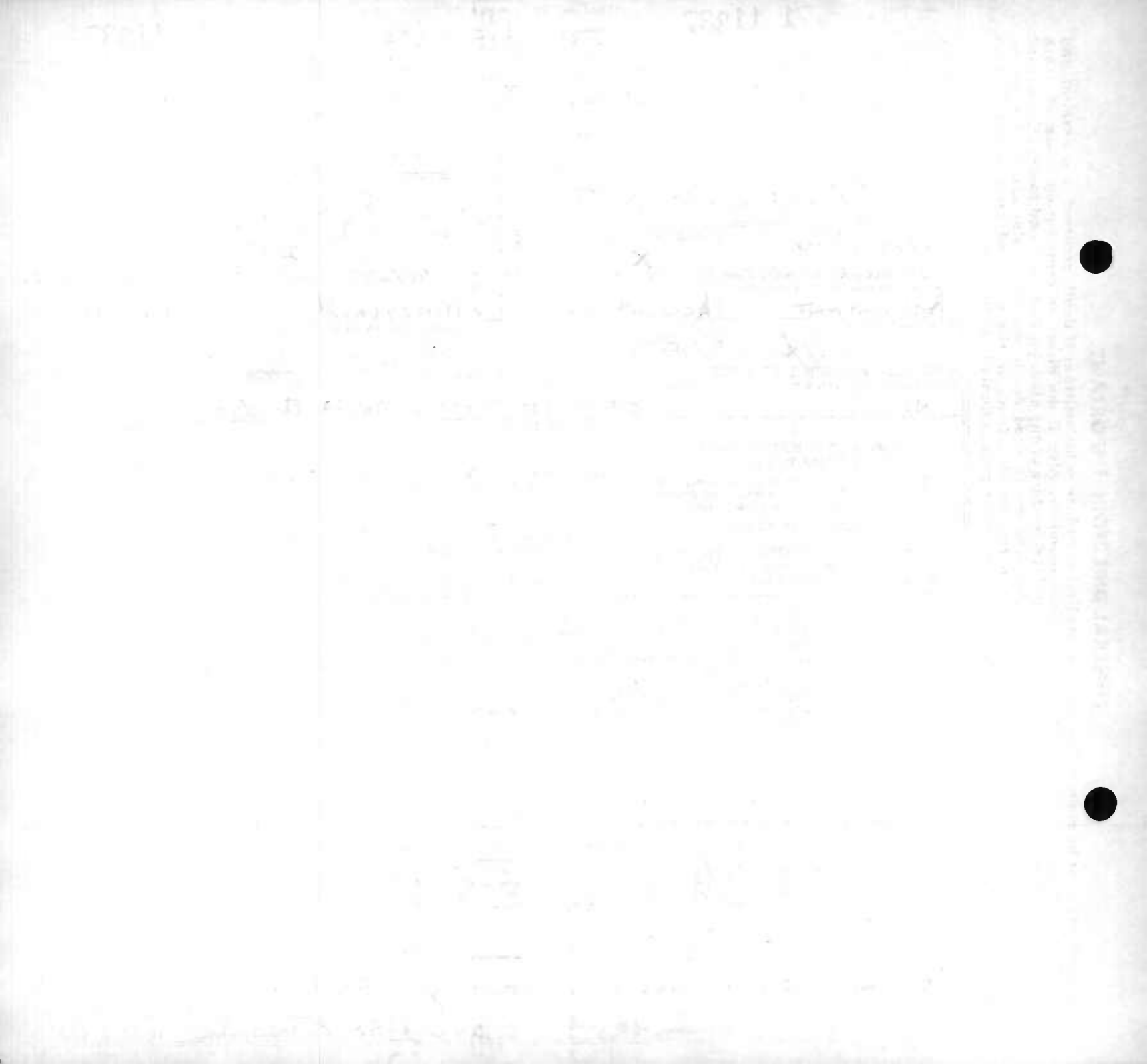
BALTIMORE, MARYLAND

ST. LOUIS RAILROAD

FUNERAL DIRECTOR: IMPORTANT

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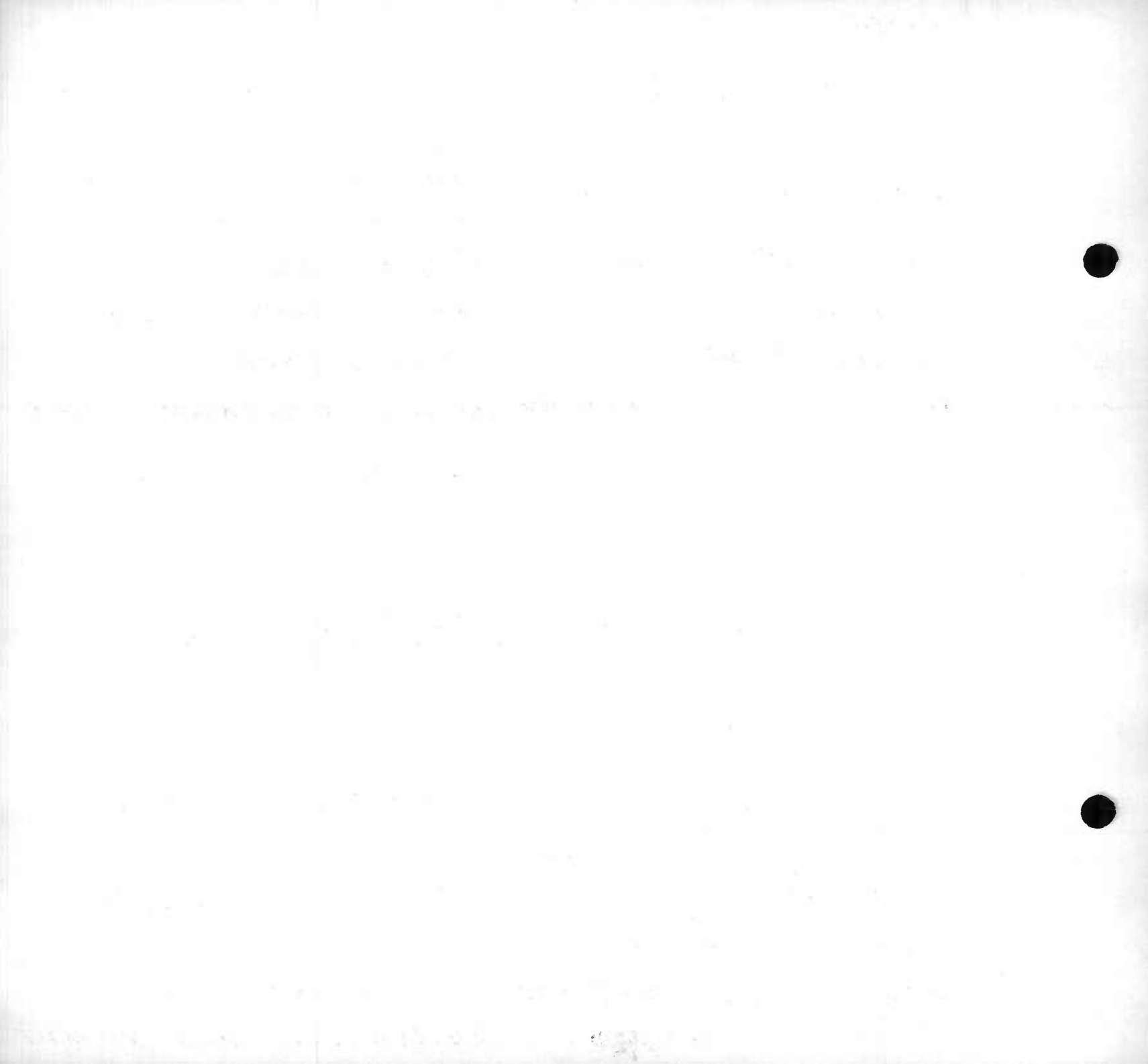
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11337	
T-620 71 11337				BIRTH NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
William GLEN Towers				Dec 4 1971 - 10:29 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE		B. COUNTY	
37 Mercy Hospital				Md		Baltimore	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				TOWSON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
m				24		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Accountant				Accounting		6-29-98	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Alexia Towers				Bessie Crown		73	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				213-10-1930		Stella Marie Hospice	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 hr.	
ANTECEDENT CAUSES				(B) Severe toxic metabolic disorder		2 wks.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Diabetic mellitus, GI bleeding		yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Site undetermined, EVA 2 @ Hagerstown		1 wk.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
12/4/71		Resp. w/ (Hagerstown)		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
1 Month 1 Day 1 Year 1 Hour		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
E. Lee Robbins				12/6/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
E. Lee Robbins							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-9-71		OAKLAWN CEMETERY		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 8 1971		Robert E. Taylor		Wm. Cook-Brooks Towson, Inc.		Towson, Md.	



FUNERAL DIRECTOR: IMPORTANT

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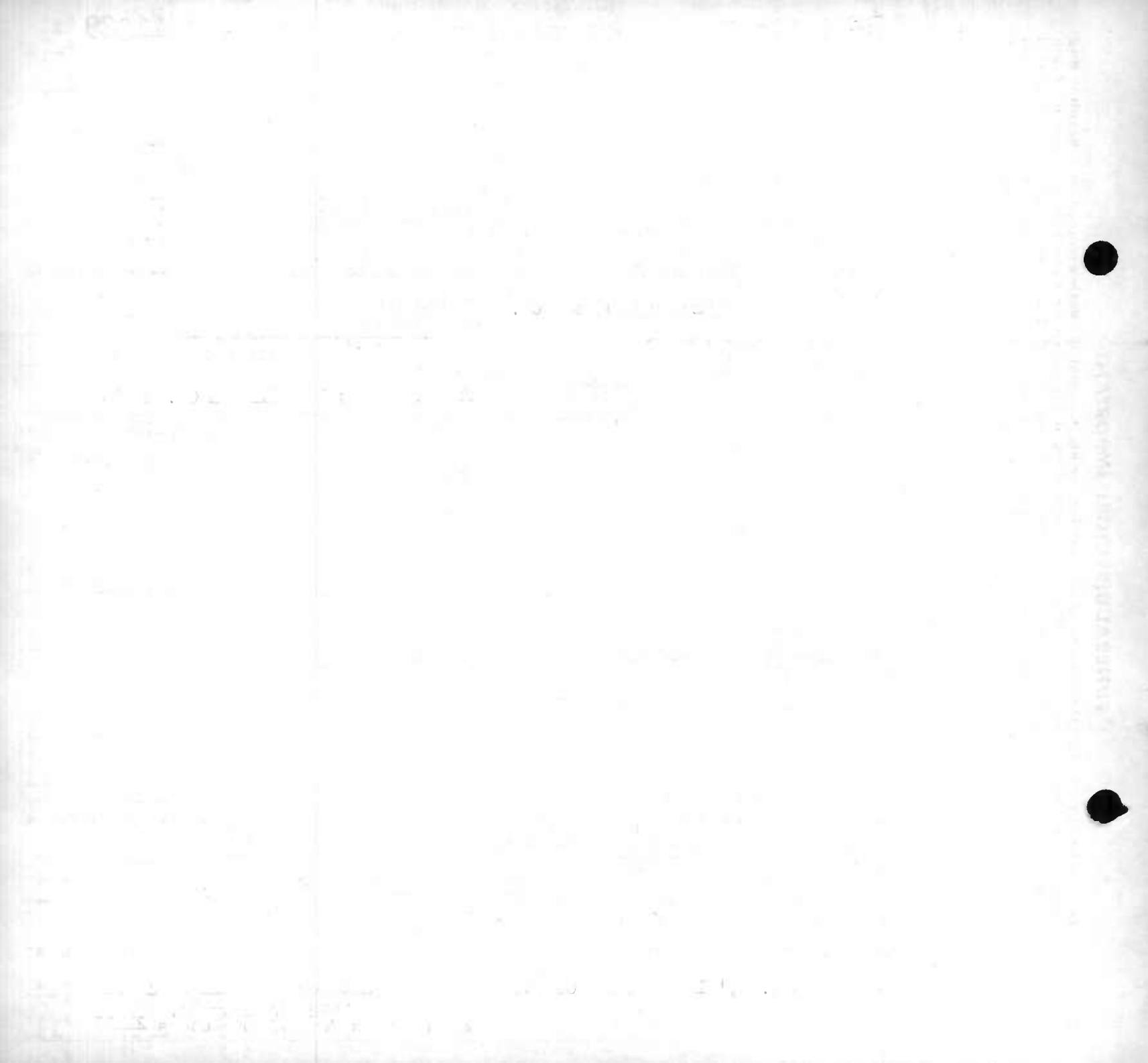
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11338	
0-125 BIRTH NO. 71 11338							
1. NAME OF DECEASED (Type or Print) ANNA F. OPACENSKY				2. DATE AND HOUR OF DEATH 12/4/71 1:10 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION GOULD N.H. BELAIR RD.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BOWLE & WATERS		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/1/88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 83		If Under 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME VINCENT KOUBA				14. MOTHER'S MAIDEN NAME FRANCIS SKOP			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-22-9650		17. INFORMANT ADELINE OPACENSKY ABOVE		ADDRESS	
18. 422.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Pancreatitis				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Congestive Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Congestive Heart Failure				(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Congestive Heart Failure		(C) DUE TO, OR AS A CONSEQUENCE OF: Chronic Congestive Heart Failure	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Uning Trust Spine - Post-op Complication of Catheter							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/22/71 to 12/4/71 that (I) (we) last saw the deceased alive on 11/30/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 12/4/71		23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/7/71		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-35271 11339		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 71 11339	
1. NAME OF DECEASED (Type or Print) OTTENS, INGRID E				2. DATE AND HOUR OF DEATH Dec 5 1971 11 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland (U.S.) B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44		C. CITY OR TOWN Randallstown		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07-30-51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Harper Robinson Co.		9. AGE (In years last birthday) 20		11. BIRTHPLACE (State or foreign country) Florida	
13. FATHER'S NAME OTTO OTTENS		14. MOTHER'S MAIDEN NAME ANTONIA Smith (Smit)		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Otto H. Ottens 3608 Laguna Ct. 21133		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH Brain Herniation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Brain Herniation		3 months	
				(B) Brain Tumor Brain tumor		3 months	
MEDICAL CERTIFICATION				19A. DATE OF OPERATION Oct 28 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CS# fistula	
				20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 27 1971 to Dec 5 1971 that (I) (we) last saw the deceased alive on Dec 5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Teh-ching Wang M.D.				23B. DATE SIGNED Dec 5 1971		23C. PHYSICIAN'S NAME (Type) TEH-CHING WANG	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE Dec. 7, '71		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971				25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Loring Byers Funeral Directors 21133	
24D. LOCATION Baltimore Woodlawn Maryland				25D. ADDRESS 8728 Liberty Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

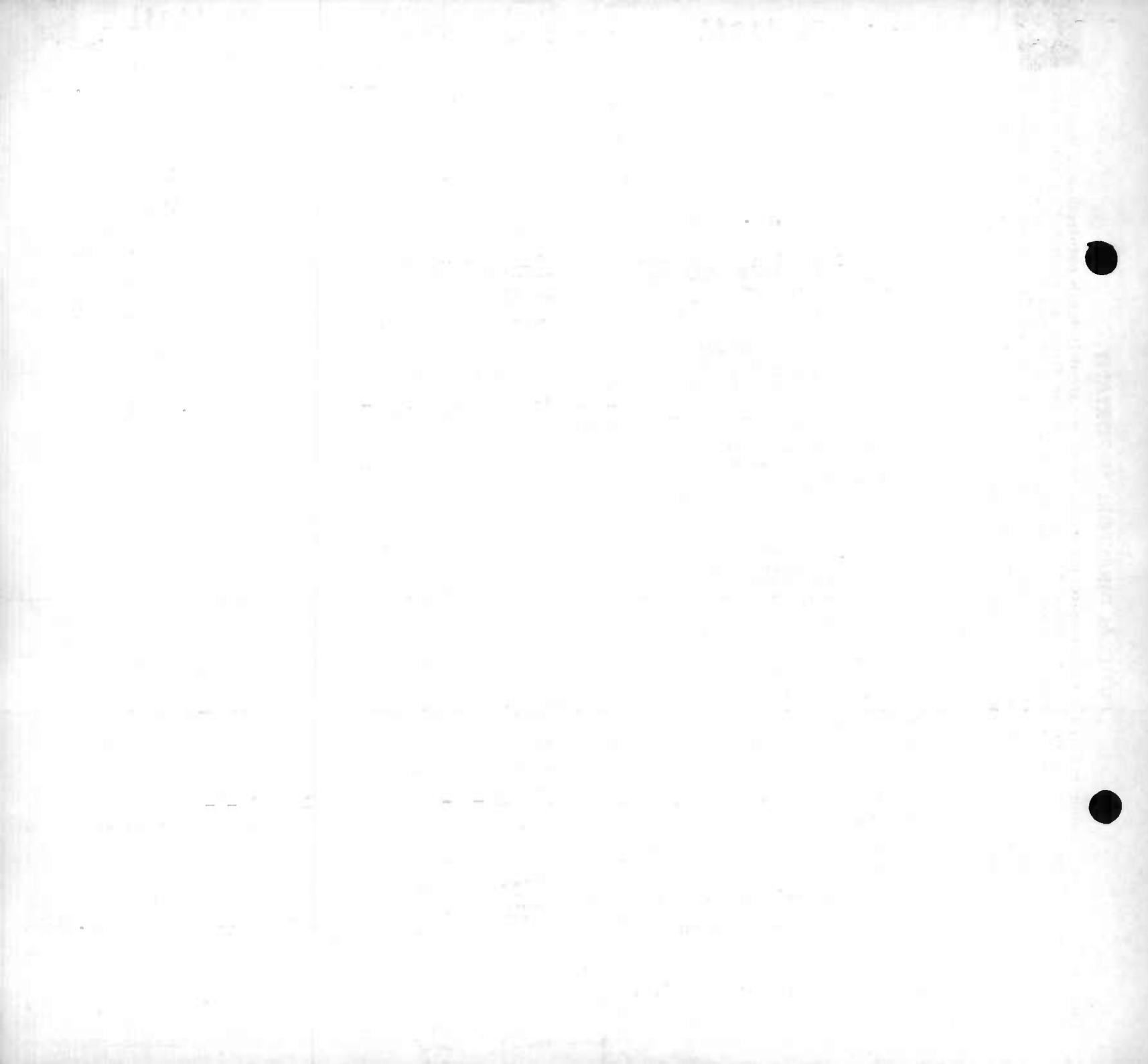
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11340	
J-530 71 11340		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Anna m. Smith		2. DATE AND HOUR OF DEATH 12-4-71 8³⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2301	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harrison nursing Home 2803 Harrison Blvd Baltimore, Md. 21216		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1200 S. Charles St.			
5. SEX F	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-1889
9. AGE (In years last birthday) 82		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Patrick Scully		14. MOTHER'S MAIDEN NAME Mary Elizabeth Bergam	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-09-8824D	
17. INFORMANT Thomas Smith 1200 S. Charles St.		ADDRESS	
18. 438.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL VASCULAR DIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. SENILE BRAIN SYNDROME		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Phillip E. B. Byrd, Jr. M.D.		23B. DATE SIGNED 12/4/71	
23C. PHYSICIAN'S NAME (Type) PHILLIP E. B. BYRD, Jr. M.D.		23D. ADDRESS 2707 HANSON AVE. BALTO. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/71	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Highway Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR KRAUSE FUNERAL HOME		ADDRESS 1216 S. Charles St.	



FUNERAL DIRECTOR: IMPORTANT

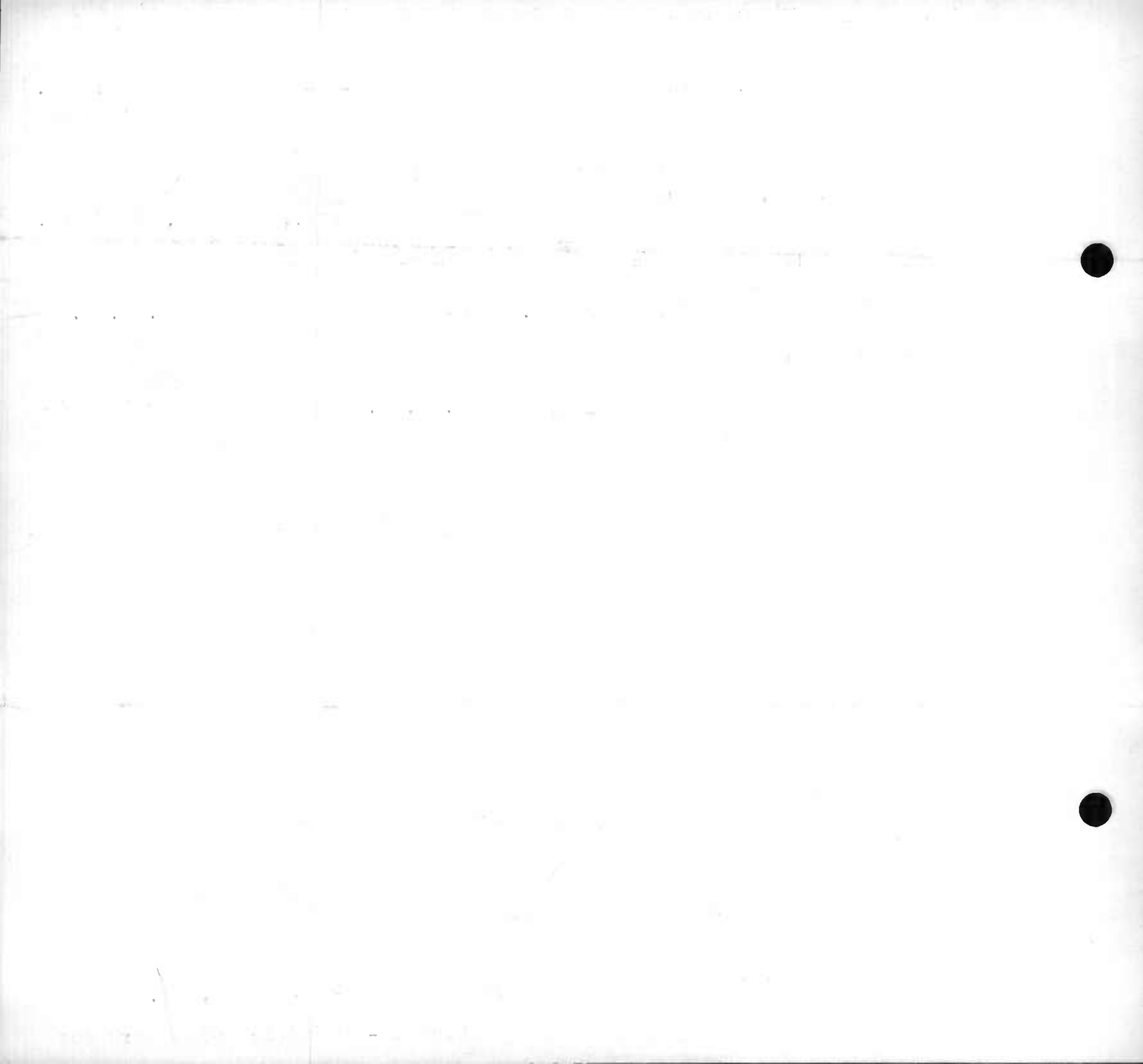
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11341	
BIRTH NO. H-400 71 11341				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mary A. Healy			2. DATE AND HOUR OF DEATH 12-6-1971 1:40A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 2636		
5. SEX Female		6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-3-1889
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		9. AGE (in years last birthday) 82	11. BIRTHPLACE (State or foreign country) md
13. FATHER'S NAME Joseph Cole			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 214-14-8012		14. MOTHER'S MAIDEN NAME Elizabeth ?
17. INFORMANT Records: BCH-4940 Eastern Ave.,			ADDRESS 21224		
18. 412.419.250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CVA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, ASCVD			CAUSE OF DEATH CVA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). diabetes mellitus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-23- 19 71 to 12-6- 19 71 that (I) (we) last saw the deceased alive on 12/5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leon Landau MD			23B. DATE SIGNED 12/6/71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Leon Landau			23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. 21224 Baltimore City Hospitals		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/71		24C. NAME of CEMETERY or CREMATORY New Cathedral Com	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR John J. Gowan	
25D. ADDRESS 23 W. 1st					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>C-345 71 11342</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 11342</p>	
<p>1. NAME OF DECEASED (Type or Print) JOHN H. CATLIN</p>		<p>2. DATE AND HOUR OF DEATH 12-03-71 9:30 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1202</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33 BALTIMORE, MD 21218</p>		<p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Charles BLACKSTONE APTS., 33RD & XXXXXX STS.</p>	
<p>5. SEX MALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 07-08-89 9. AGE (In years last birthday) 82 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Insurance Co.</p>	
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>	
<p>13. FATHER'S NAME JAMES CATLIN</p>		<p>14. MOTHER'S MAIDEN NAME EMMA EVANS</p>	
<p>15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 212-03-1585</p>	
<p>17. INFORMANT Mrs. A. L. Hammond</p>		<p>ADDRESS 2315 Maryland Ave</p>	
<p>18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO-RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ATHEROSCLEROTIC DISEASE</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MANY YEARS</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Involuntarily medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from Dec 1 19 71 to Dec 3 19 71 that (1) (we) last saw the deceased alive on Dec 3 9:30 PM 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Michael Karpf M.D.</p>		<p>23B. DATE SIGNED Nov 3 1971</p>	
<p>23C. PHYSICIAN'S NAME (Type) Michael Karpf M.D.</p>		<p>23D. ADDRESS Johns Hopkins Hosp.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 12/7/71</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Chester Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Chestertown, Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</p>	
<p>25C. FUNERAL DIRECTOR Mitchell-Wiedefeld</p>		<p>ADDRESS 6500 York Road</p>	



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		71 11343		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		71 11343		REG. NO.	
1. NAME OF DECEASED (Type or Print) Chris Rhynsburger				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 4 71 6:00 A.M.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 4 71 6:00 A.M.		5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE Maryland B. COUNTY 1205		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4-8 Maryland General Hospital				E. STREET AND NUMBER 1309-11 N. Charles Street		13. FATHER'S NAME H. S. Rhynsburger		15. MOTHER'S MAIDEN NAME Grace (Wolf)		18. INFORMANT ADDRESS Newman Funeral Chapel - Oskaloosa, Iowa	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) 59		11. BIRTHPLACE (State or foreign country) Oskaloosa, Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
9. DATE OF BIRTH Jan. 20, 1912		10. AGE (In years last birthday) 59		11. BIRTHPLACE (State or foreign country) Oskaloosa, Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME H. S. Rhynsburger		15. MOTHER'S MAIDEN NAME Grace (Wolf)	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Grace (Wolf)		18. INFORMANT ADDRESS Newman Funeral Chapel - Oskaloosa, Iowa		19. E 890X1	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No None				17. SOCIAL SECURITY NO. ?		18. INFORMANT ADDRESS Newman Funeral Chapel - Oskaloosa, Iowa		19. E 890X1		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Smoke & soot inhalation DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		(D) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		(D) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1309-11 N. Charles Street 1205			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12 4 71 5:45A				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Incident to conflagration			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				24. DATE 12/6/1971				25. NAME OF REGISTRAR Robert E. Sabey, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation				24B. DATE 12/6/1971				24C. NAME OF CEMETERY or CREMATORY Loudon Park Crematory			
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971				25B. NAME OF REGISTRAR Robert E. Sabey, M.D.			
25C. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc.				25D. DATE SIGNED 12-6-71				25E. NAME OF REGISTRAR Robert E. Sabey, M.D.			

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71 11344

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11344

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DAVID THRASHER

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ Nov 30, 1971 M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 UNION MEMORIAL HOSPITAL

3. DATE PRONOUNCED DEAD Month Day Year Hour
November 30, 1971 8:40 P. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 1305

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Aug 10 1930

10. AGE (In years last birthday)

41

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

3146 Keswick Road

11. BIRTH PLACE (State or foreign country)

Cumberland Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Nelson D. Thrasher

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanic

14B. KIND OF BUSINESS OR INDUSTRY

M Vernon Mills

15. MOTHER'S MAIDEN NAME

Dolphia P. Flanigan

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)

Yes

WW II

17. SOCIAL SECURITY NO.

18. INFORMANT ADDRESS
Mrs. David Thrasher Balto Md.I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

II. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Laryngo-tracheo-bronchitis and bronchopneumonia

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Arteriosclerotic cardiovascular disease

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

1

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/1/71

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/4/71

24C. NAME OF CEMETERY or CREMATORY

Bairtown Cem.

24D. LOCATION (City, town, or county) (State)

Bairtown Allegany Md.

25. DATE REC'D BY HEALTH DEPT.

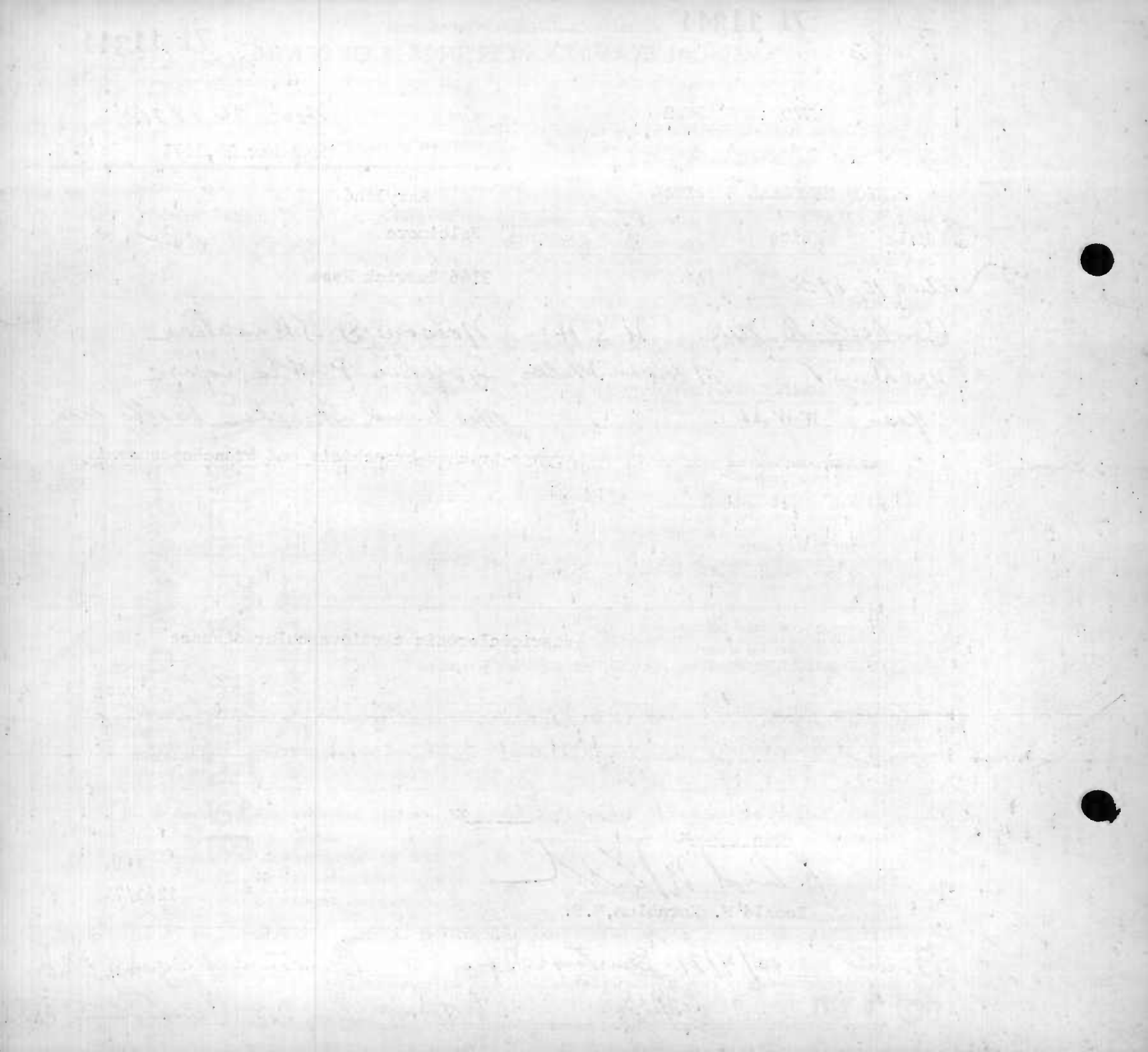
DEC 8 1971

26B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

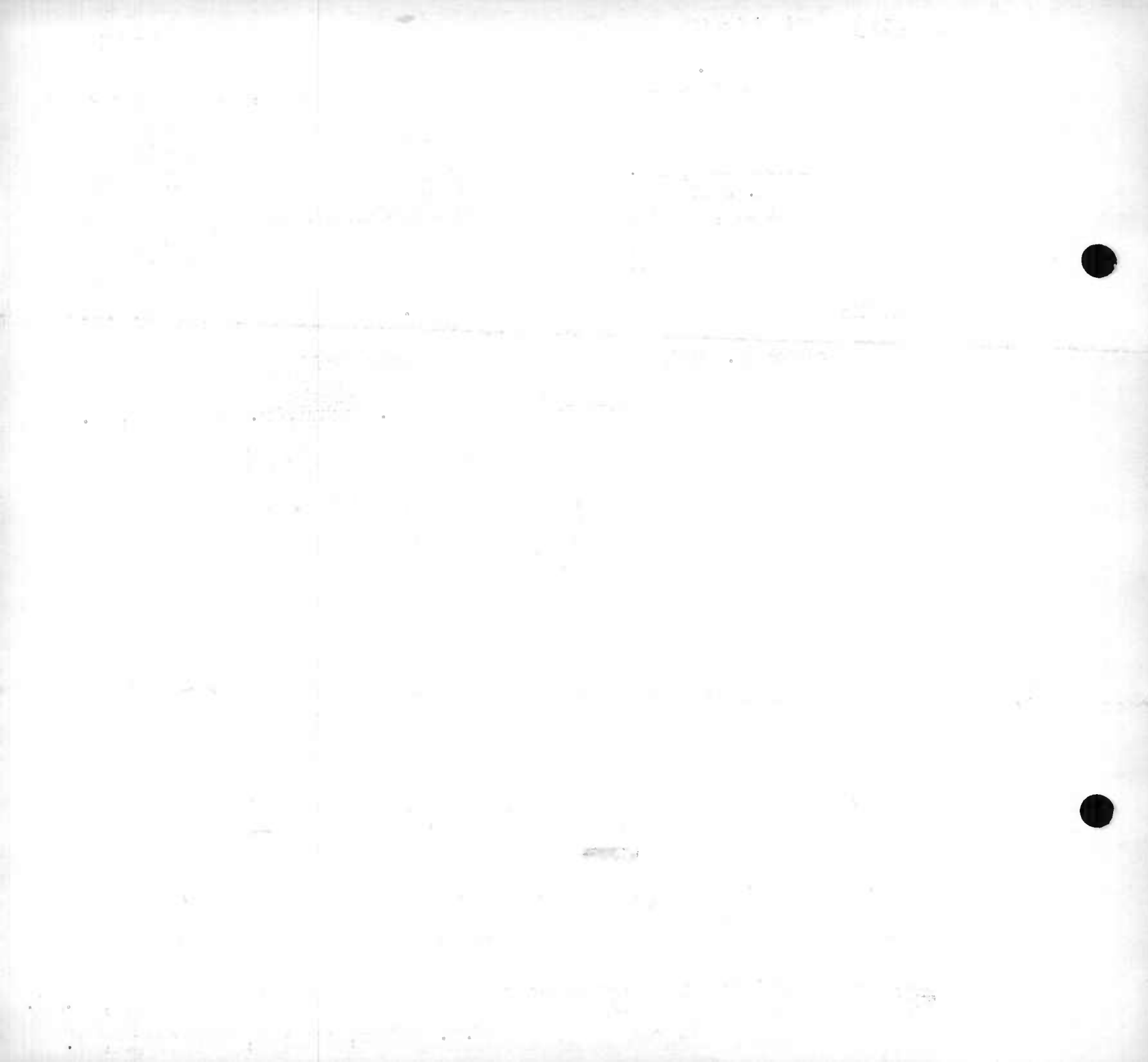
Louis Stein Inc. Cumberland Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

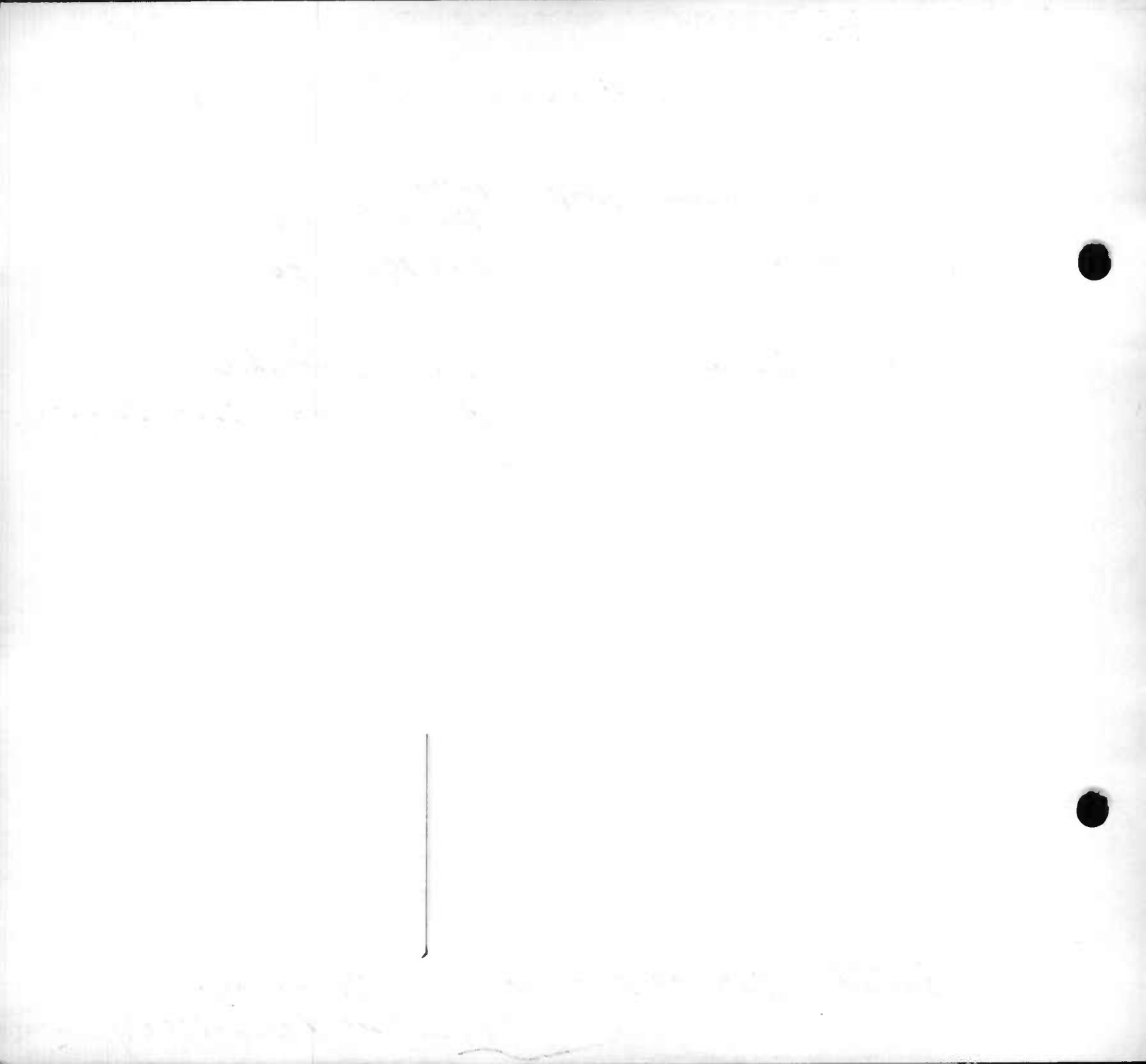
G-500 71 11345		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11345	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		R. Augusta GUYNN		December 2, 1971 11:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 90		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202		Maryland		2641	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/30/84	
9. AGE (In years last birthday) 87		10. AGE (In years last birthday) 87		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Joseph M. Ruff		14. MOTHER'S MAIDEN NAME Kate Ladd	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-56-5790		17. INFORMANT Horace G. Guynn, Jr. Woodbine, Md.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cardio Respiratory Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ac Myocardial Infarction (B) Hypertension - Art & V + D DUE TO, OR AS A CONSEQUENCE OF: (C) Gen. Atherosclerosis Senility		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 11 19 63 to December 2 19 71 that (I) (we) lost saw the deceased alive on Dec 2 19 71 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.							
23A. SIGNATURE Willard Appleford		23B. DATE SIGNED 12/2/71		23C. PHYSICIAN'S NAME (Type) Willard Appleford		23D. ADDRESS 6615 Neisterbaum Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/1971		24C. NAME OF CEMETERY or CREMATORY Taylorsville		24D. LOCATION (City, town, or county) (State) Taylorsville, Carroll Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR C.M. Waltz, Box 326, Sykesville, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-252 71 11346		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11346	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MRS. Esther Hawkins</i>		2. DATE AND HOUR OF DEATH <i>December 6 1971 10:00 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Box Secum Hosp</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>1901</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>326 N. Tricker St</i>					
5. SEX <i>Female</i>	6. RACE <i>Black</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-19-1901</i>	9. AGE (In years last birthday) <i>70</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>United States</i>		13. FATHER'S NAME <i>Albert Moore</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Fisher</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-26-5985</i>		17. INFORMANT <i>Anita D. White Briensticker</i>	
18. <i>162.141250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Diabetes Mellitus</i>		CAUSE OF DEATH <i>Carcinomatous lungs</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Year</i>	
19A. DATE OF OPERATION <i>12/4</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>	
22. I certify that (t) (this hospital) attended the deceased from <i>12/4</i> 19 <i>71</i> to <i>12/6</i> 19 <i>71</i> that (t) (we) last saw the deceased alive on <i>12/6</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (t) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Anita D. White Briensticker</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>ARVORANEE BICHAIRONARONGSONGURAMP</i>				23D. ADDRESS <i>BON SECOURS HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12/8/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MAAVERN</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Theresa A. P. Hays</i>		25D. ADDRESS <i>638 N. G. L. M. St</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 8-3431 11347		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11347	
1. NAME OF DECEASED (Type or Print) STULTZ, ELIZABETH B.			2. DATE AND HOUR OF DEATH DEC. 3, 1971 7:30P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE GOOD SAMARITAN HOSPITAL 45 LOCH RAVEN and BELVEDERE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2552		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3001 Cerryland Rd.		
5. SEX F	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-11-20	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) supermarket checker			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert			14. MOTHER'S MAIDEN NAME Thelma Daniels		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 578-18-5992		17. INFORMANT Mrs. Thelma C. Daniels ADDRESS 1938 WATBROOK AVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 162-1-011.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory failure Metastatic Adenocarcinoma of Lung chip Tuberculosis of lung ? years			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) chip		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II Tuberculosis of lung					
19A. DATE OF OPERATION 11-04		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19 71 to 12-03-71		20A. AUTOPSY? (Yes or No) 19 71 to 12-03-71	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) chip		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) chip	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? chip	
22. I certify that (I) (this hospital) attended the deceased from 11-04 19 71 to 12-03-71 19 , that (I) (we) last saw the deceased alive on 12-03 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Juan M.D.				23B. DATE SIGNED 12-03-71	
23C. PHYSICIAN'S NAME (Type) DAVID JUAN M.D.				23D. ADDRESS Good Samaritan Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-1971		24C. NAME of CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Md.		24E. NAME of REGISTRAR Marshall W. Jones, Jr.			
25A. DATE REC'D BY HEALTH DEPT. 8 1971		25B. NAME OF REGISTRAR Marshall W. Jones, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 11348</u>	
BIRTH NO. <u>H-400</u>		71 11348					
1. NAME OF DECEASED (Type or Print) <u>MAYMIE WATERS HALL</u>				2. DATE AND HOUR OF DEATH <u>Dec 4, 1971</u> <u>8:10</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1001</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1213 HARFORD AVE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-00</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Holly, La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JESSE DAVIS</u>			14. MOTHER'S MAIDEN NAME <u>NANCY FRENCH</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-07-8566B</u>		17. INFORMANT <u>Rev. William A. Hall 1213 Harford Ave. 21202</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____ DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>Dec 4th</u> 19 <u>71</u> to <u>Dec 4</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Dec 4</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.							
23A. SIGNATURE <u>George J. Taylor IV, MD</u>				23B. DATE SIGNED <u>Dec 4, 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>George J. Taylor IV</u>				23D. ADDRESS <u>John's Hopkins Hosp Baltimore Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-8-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1971</u>		25B. NAME OF REGISTRAR <u>Marshall W. Jones, Jr.</u>		25C. FUNERAL DIRECTOR <u>1735 Harford Ave. 21213</u>			



71 11349

THE HISTORY OF THE UNITED STATES

The history of the United States is a story of growth and change. It begins with the first people who lived on this land, and continues through the years of exploration, settlement, and the struggle for independence. The story is one of a people who have built a nation of freedom and opportunity, and who have played a leading role in the world.

The first people to live in North America were the Indians. They had lived there for thousands of years, and had developed a rich and varied culture. They were the first to teach the Europeans about the land, and they were the first to be conquered by them. The story of the Indians is a story of tragedy and loss, but it is also a story of resilience and survival.

The Europeans came to North America in the 15th century, and they brought with them a new way of life. They were the first to build a permanent settlement, and they were the first to declare independence. The story of the Europeans is a story of discovery and adventure, but it is also a story of conflict and struggle.

The United States was born in 1776, and it has since grown into a great nation. It has been a land of freedom and opportunity, and it has played a leading role in the world. The story of the United States is a story of a people who have built a nation of freedom and opportunity, and who have played a leading role in the world.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11350

REG. NO. 71 11350

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Tillie Donnerson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 2 Year 71 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 235 S. Spring Ct.		3. DATE PRONOUNCED DEAD Month 12 Day 2 Year 71 Hour 8:35 a. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 301	
6. SEX female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2-15-19		10. AGE (in years lost birthday) 52		E. STREET AND NUMBER 235 S. Spring Ct.	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF U.S.A.		13. FATHER'S NAME Pierrece Donnerson	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Nannie Thompson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Ella McKens 235 Spring Ct.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/2/71					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-71		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Em. & A. Co.	
24D. LOCATION (City, town, or county) (State) Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Rayner Sanders		25D. ADDRESS 217 E. Preston			

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BALTIMORE CITY HEALTH DEPARTMENT

71 11351

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11351

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANCES A. WARNER (Warner)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 312 Camden St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 5 1971 11:08 PM.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 9-30-35		10. AGE (in years lost birthday) 36	
11. BIRTHPLACE (State or foreign country) Asheville, N.C.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT ADDRESS Mr. George Warner - 1411 W. Baltimore St.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		21. AUTOPSY? (Yes or No) yes CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-6-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-71	
24C. NAME OF CEMETERY OR CREMATORY New-Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles E. Fisher		25D. ADDRESS 1532 Hollins St	

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K-200 71 11352 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 11352

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALEXANDER KEYES (AKA) Keyes		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1823 N. Pulaski Street		3. DATE PRONOUNCED DEAD Month Day Year Hour December 1, 1971 12:50 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov 5, 1900		10. AGE (In years last birthday) 71	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		14B. KIND OF BUSINESS OR INDUSTRY Self Employed	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-54-1841	
15. MOTHER'S MAIDEN NAME Maggie Brown		18. INFORMANT Mrs Brenda Reid	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 412.41 250.9	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Diabetes mellitus		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12/1/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 4, 1971	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem		24D. LOCATION (City, town, or county) (State) Westport MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Joseph L. Russ		ADDRESS 2022 W. North Ave	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-552 71 11353 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. _____ </div>			
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>William Charles Schmincke</i>		2. DATE AND HOUR OF DEATH <i>December 6, 1971</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 South Baltimore General Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2402</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>726 East Fort Avenue</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 3, 1898</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Polisher & Buffer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	9. AGE (in years last birthday) <i>73</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME _____		14. MOTHER'S MAIDEN NAME <i>Elizabeth Frank</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <i>Vivian Mickey</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Ante Cordium Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerosis</i>		DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____			
19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <i>Dec 1, 1965</i> to <i>Dec 6, 1971</i> that (I) (we) last saw the deceased alive on <i>Nov. 30, 1971</i> and that (in my) (our) opinion death occurred on the date <i>Dec 6, 1971</i> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>D.O.A. at SBGH</i>			
23A. SIGNATURE <i>A. C. Sollod M.D.</i>		23B. DATE SIGNED <i>12-7-71</i>	23C. PHYSICIAN'S NAME (Type) <i>A. C. SOLLGD M.D.</i>
23D. ADDRESS <i>707 FORT AVE BALTO. Md. 21202</i>		23E. FUNERAL DIRECTOR <i>McGully Funeral Home Balto., Md. 21230</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12-10-71</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 21225</i>
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1971</i>		25B. NAME OF REGISTRAR <i>John E. Taylor, M.D.</i>	25C. FUNERAL DIRECTOR <i>McGully Funeral Home Balto., Md. 21230</i>

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B-110

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11354	
<div style="display: flex; justify-content: space-between;"> B-160 71 11354 </div>					
1. NAME OF DECEASED (Type or Print) PAUL E. BEAVER			2. DATE AND HOUR OF DEATH 3 DECEMBER 1971 2:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD NORTH CHARLES GEN. HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY NOWARD C. CITY OR TOWN CLARKSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX M 6. RACE CAUCASIAN 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1/21/1890 9. AGE (in years last birthday) 81 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			11. BIRTHPLACE (State or foreign country) MARYLAND		
10B. KIND OF BUSINESS OR INDUSTRY FARMING			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME JOHN BEAVER (D)			14. MOTHER'S MAIDEN NAME MATTIE DIERL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 315-321-386		
17. INFORMANT DAUGHTER ADDRESS F320 SUNSET DR. 21043					
18. 4-36-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CVA (cerebrovascular accident) DUE TO, OR AS A CONSEQUENCE OF: (B) HYPERTENSIVE VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 12/4/71 19 71 to 12/3 19 71 that (I) (we) last saw the deceased alive on 2:30 PM 12/3/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 12/3/71		
23C. PHYSICIAN'S NAME (Type) GATON H. ESCOBARTE M.D.			23D. ADDRESS NORTH CHARLES GEN. HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-6-71		24C. NAME OF CEMETERY or CREMATORY PROVIDENCE Cem.	
24D. LOCATION (City, town, or county) CLARKSVILLE Md.		24E. DATE REC'D BY HEALTH DEPT. DEC 8 1971		24F. NAME OF REGISTRAR [Signature]	
24G. DATE REC'D BY HEALTH DEPT. DEC 8 1971		24H. NAME OF REGISTRAR [Signature]		24I. FUNERAL DIRECTOR ADDRESS Higginbotham - 5106 ELLICOTT CITY MD 21043	



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J-520 71 11355

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11355

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) MAMIE JAMES		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1815 N. Fulton Avenue		3. DATE PRONOUNCED DEAD December 7, 1971		Month Day Year		Hour M. 11:40 P.	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-27-92		10. AGE (In years lost birthday) 79		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF U. S. A.	
13. FATHER'S NAME John Washington		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Annie Washington		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Esther Rodgers		ADDRESS 1815 N. Fulton Avenue		19. 412.41	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. DATE OF OPERATION		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		27. AUTOPSY? (Yes or No) no	
28. TIME (Month) (Day) (Year) (Hour) (APPROX.)		29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30. HOW DID INJURY OCCUR?		31. DATE SIGNED 12/8/71	
32. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		33. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		34. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		35. DATE SIGNED 12/8/71	
36. BURIAL CREMATION, REMOVAL (Specify) Burial		37. DATE 12-11-71		38. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		39. LOCATION (City, town, or county) (State) Baltimore, Maryland	
40. DATE REC'D BY HEALTH DEPT. DEC 8 1971		41. NAME OF REGISTRAR Blair E. ...		42. FUNERAL DIRECTOR Morton & Dyett F. H.		43. ADDRESS 1701 Laurens St.	

VS 151-REV. 1/1/68

11-11-57

John W. Johnson

John W. Johnson

John W. Johnson

John W. Johnson

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John W. Johnson

John W. Johnson

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71 11356

BALTIMORE CITY HEALTH DEPARTMENT

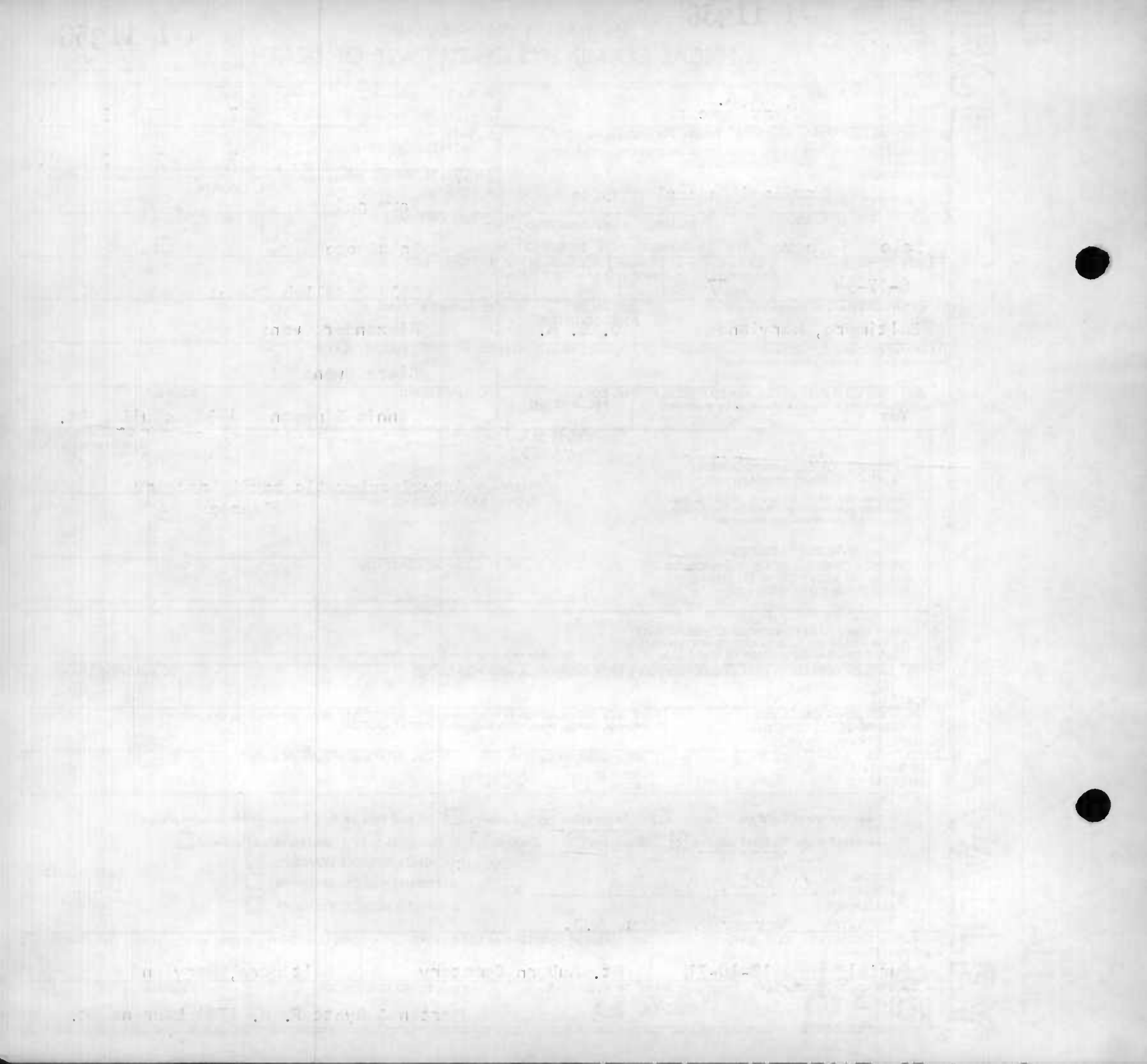
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11356

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) A. Edward Owens		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 7 71 3:30 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 4-8 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 7 71 3:30 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 14-03	
9. DATE OF BIRTH 6-17-94		10. AGE (in years lost birthday) 77 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Owens		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Clara Owens		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Jennie Simpson 1838 McCulloh St.	
19. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-7-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECD BY HEALTH DEPT. DEC 8 1971 Robert E. Taylor, M.D.		25B. NAME OF REGISTRAR Morton & Dyett F. H.	
25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens St.			



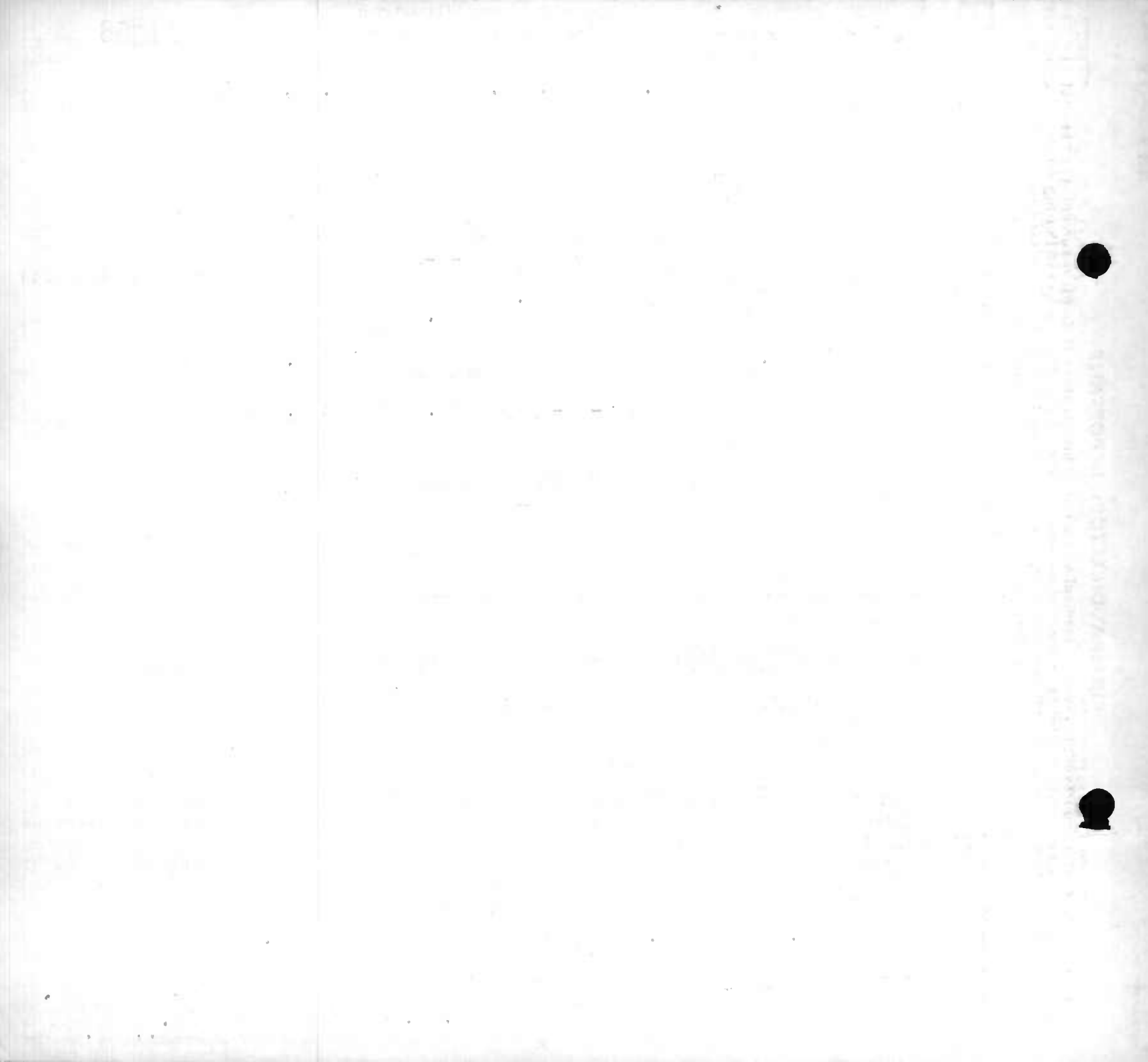
M-231 **71 11357** **BALTIMORE CITY HEALTH DEPARTMENT**
MEDICAL EXAMINER'S CERTIFICATE OF DEATH **71 11357**
 BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) Juliet B. McDavid		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 7 Year 71 Hour 10:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 101 Long Wood Road		3. DATE PRONOUNCED DEAD Month 12 Day 7 Year 71 Hour 10:15 A.M.	
6. SEX Female 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2713	
9. DATE OF BIRTH 9-17-1915 10. AGE (In years last birthday) 56 11. BIRTHPLACE (State or foreign country) Washington, D.C.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 101 Long Wood Road	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		13. FATHER'S NAME Robert S. Belknap	
14B. KIND OF BUSINESS OR INDUSTRY Own Home		15. MOTHER'S MAIDEN NAME Louise C. Cole	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-40-8648	
18. INFORMANT Mr. Thomas O. McDavid		ADDRESS Same	
19. 412.2 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE Arteriosclerotic and hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 12/9/71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-7-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/1971	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	

FUNERAL DIRECTOR: IMPORTANT

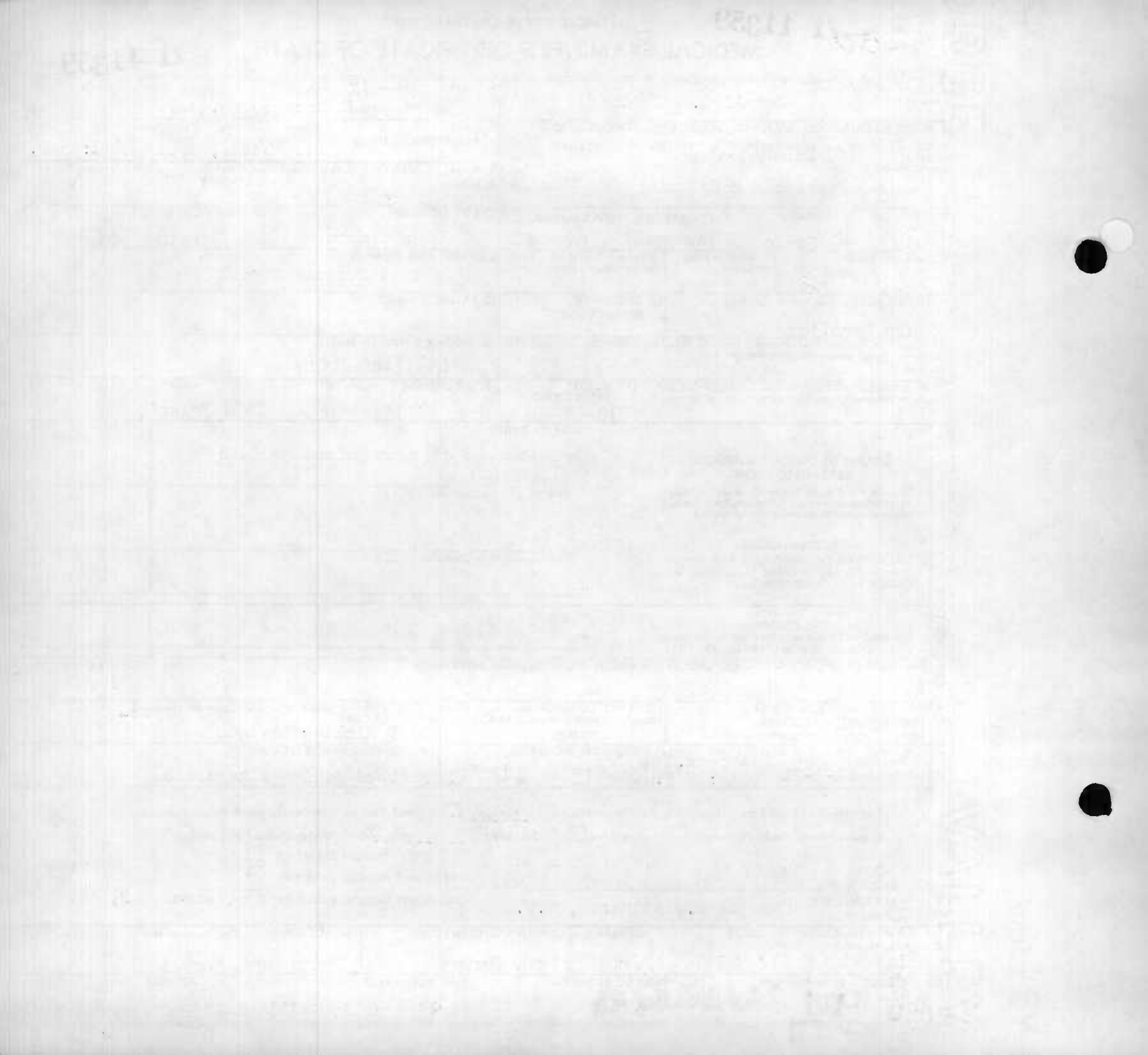
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11358	
G-650 71 11358				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
William T. Graham, Jr.		Dec. 7, 1971		2 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 4205 Tuscany Court		A. STATE Maryland		B. COUNTY 1201	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4205 Tuscany Court 21210			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-9-1907	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Insurance		10B. KIND OF BUSINESS OR INDUSTRY Maryland Casualty Co.		11. BIRTHPLACE (State or foreign country) Pa.	
13. FATHER'S NAME William T. Graham		14. MOTHER'S MAIDEN NAME Louise E. Theobald		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 180-09-4370		17. INFORMANT Mrs. William T. Graham	
18. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive Heart failure</i> (B) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>Feb 14</i> 19 <i>71</i> to <i>Dec 7</i> 19 <i>71</i> and that (2) (we) last saw the deceased alive on <i>Dec 7</i> 19 <i>71</i> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. G. Helfrich</i>		23B. DATE SIGNED <i>8 Dec 71</i>		23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich	
23D. ADDRESS 5006 Roland Ave.		23E. DEGREE DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-71		24C. NAME OF CEMETERY or CREMATORY West Laurel Hill	
24D. LOCATION Philadelphia, Pa.		24E. LOCATION (City, town, or county) (State)		24F. LOCATION	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
25D. ADDRESS 4905 York Road Balto., Md. 21212		25E. ADDRESS		25F. ADDRESS	

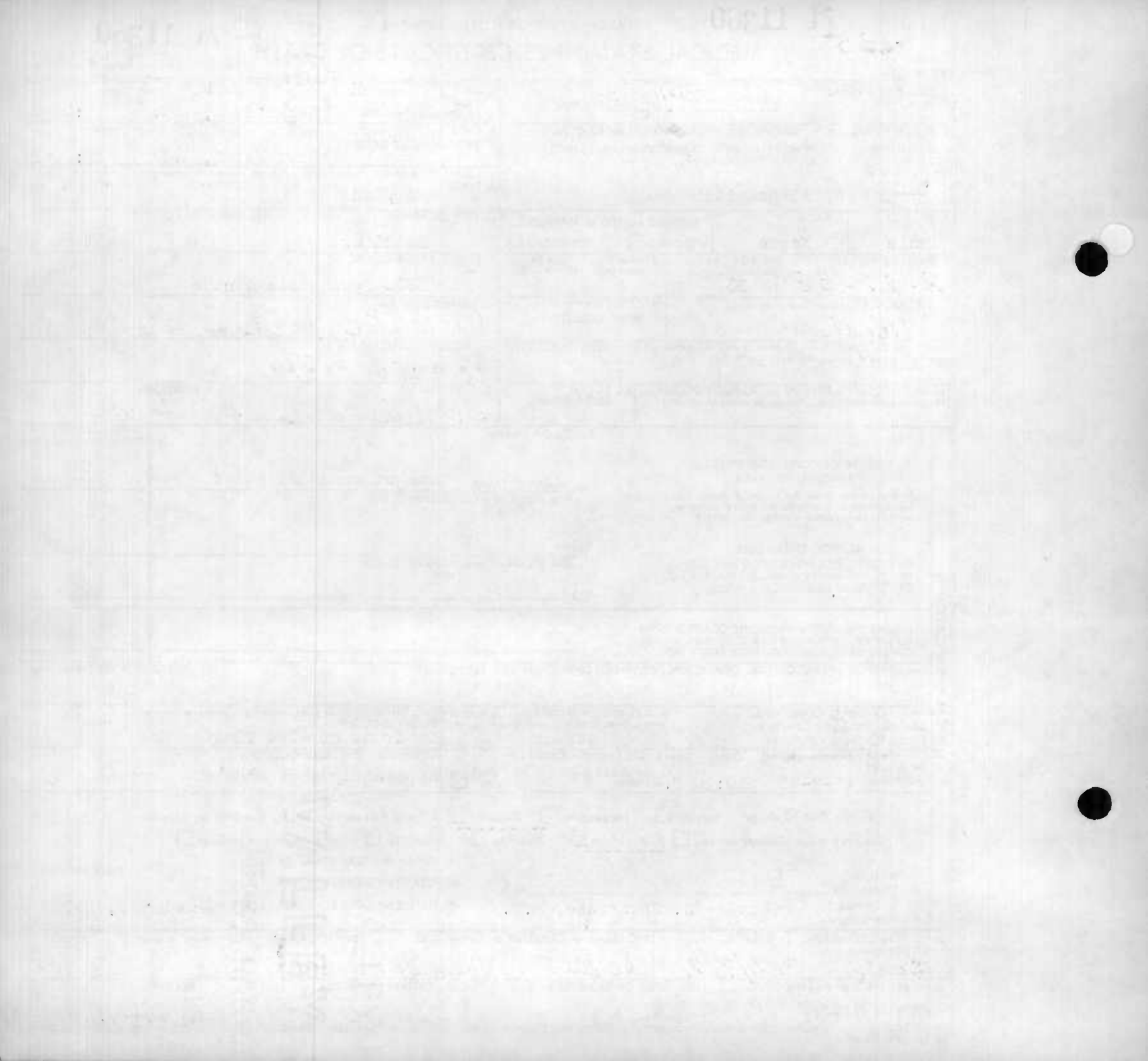


0-3571 11359 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 11359

BIRTH NO.		1. NAME OF DECEASED (Type or Print) THOMAS L. OUTTEN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 2, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year December 2, 1971 11:35 P.M.		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 1303	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 12/8/46	10. AGE (In years last birthday) 24	11. BIRTHPLACE (State or foreign country) South Carolina		E. STREET AND NUMBER 2504 Francis Street	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Lillian Outten		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 218-48-0579	
18. INFORMANT Mrs. Lillian Outten		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stabwound of neck extending into thorax (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 12		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1569 Richland Avenue 1303	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-2-71 approx. 11:10 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: December 3, 1971					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Arlington S. Phillips		25D. ADDRESS 1727 N. Monroe Street			



<p>71 11360</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p>		<p>71 11360</p> <p>REG. NO.</p>	
<p>BIRTH NO.</p>			
<p>1. NAME OF DECEASED (Type or Print) NATHANIEL M. JORDAN</p>		<p>2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour December 2, 1971 11:00 P.M.</p>	
<p>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital</p>		<p>3. DATE PRONOUNCED DEAD Month Day Year Hour December 2, 1971 11:00 P.M.</p>	
<p>6. SEX Male 7. RACE Negro</p>		<p>5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1538</p>	
<p>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>9. DATE OF BIRTH 8-26-38 10. AGE (In years last birthday) 33</p>		<p>E. STREET AND NUMBER 3706 Springdale Avenue</p>	
<p>11. BIRTHPLACE (State or foreign country) Virginia</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME Nathaniel Jordan Sr.</p>		<p>14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>	
<p>15. MOTHER'S MAIDEN NAME Annie Ricks</p>		<p>16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)</p>	
<p>17. SOCIAL SECURITY NO.</p>		<p>18. INFORMANT Phyllis Jordan ADDRESS Same</p>	
<p>19. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>20A. DATE OF OPERATION 12-2-71</p>		<p>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>21. AUTOPSY? (Yes or No) Yes</p>		<p>22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.</p>	
<p>22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street</p>		<p>22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? in front of 4224 Pimlico Road 1513</p>	
<p>22D. TIME OF INJURY (APPROX.) 12-2-71 10:10 P.M.</p>		<p>22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>	
<p>22F. HOW DID INJURY OCCUR? Apparently shot when gun accidentally dropped and discharged</p>		<p>23.</p>	
<p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.</p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 3, 1971</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 12/7/71</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Sh.</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Farley M.D.</p>	
<p>25C. FUNERAL DIRECTOR Arlington S. Phillips</p>		<p>ADDRESS 1727 N. Mount St.</p>	



71 11361
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REG. NO. 71 11361

BIRTH NO. C-552

1. NAME OF DECEASED (Type or Print) PATSY CUNNINGHAM		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 3, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2432 South Paca Street		3. DATE PRONOUNCED DEAD Month Day Year December 3, 1971 Hour 8:30 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov. 28, 1949		10. AGE (In years lost birthday) 22	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		15. MOTHER'S MAIDEN NAME Olive Mitchell	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Olive Cunningham		ADDRESS 1058 Argyle Ave	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E965 I Antecedent causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--	--	--

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2432 S. Paca Street 2543	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-3-71 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	

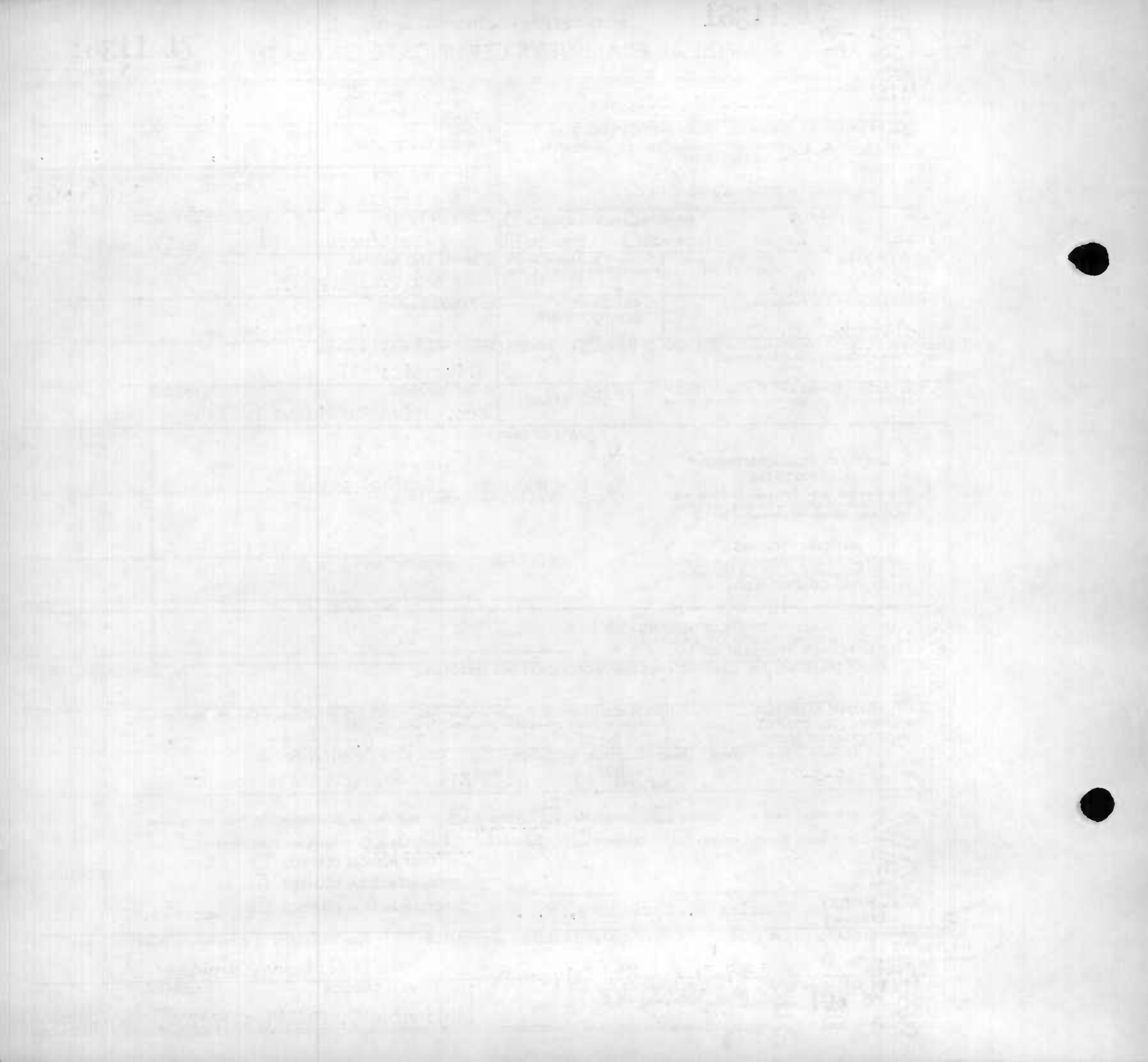
I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate, M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED December 3, 1971

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe Street			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11362

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Richard Conner		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 11 29 71 4:43 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General		3. DATE PRONOUNCED DEAD Month Day Year 11 29 71 4:43 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2552			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4-3-1919		10. AGE (In years lost birthday) 32	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Conner		14. STREET AND NUMBER 503 Bridgeview Road	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Angees Green		16. INFORMANT Mrs. Louise Conner 503 Bridgeview Road	
17. SOCIAL SECURITY NO. 427-12-3682		18. ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-71	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem.		24D. LOCATION (City, town, or county) (State) A. A. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Ruth C. Taylor, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monroe Street		ADDRESS	

~~2/1/72~~ 2/1/72 - Marriage license County of Adams, July 25, 1942.
Richard Conner and Louise Dottrey. *LBC*

FUNERAL DIRECTOR: IMPORTANT

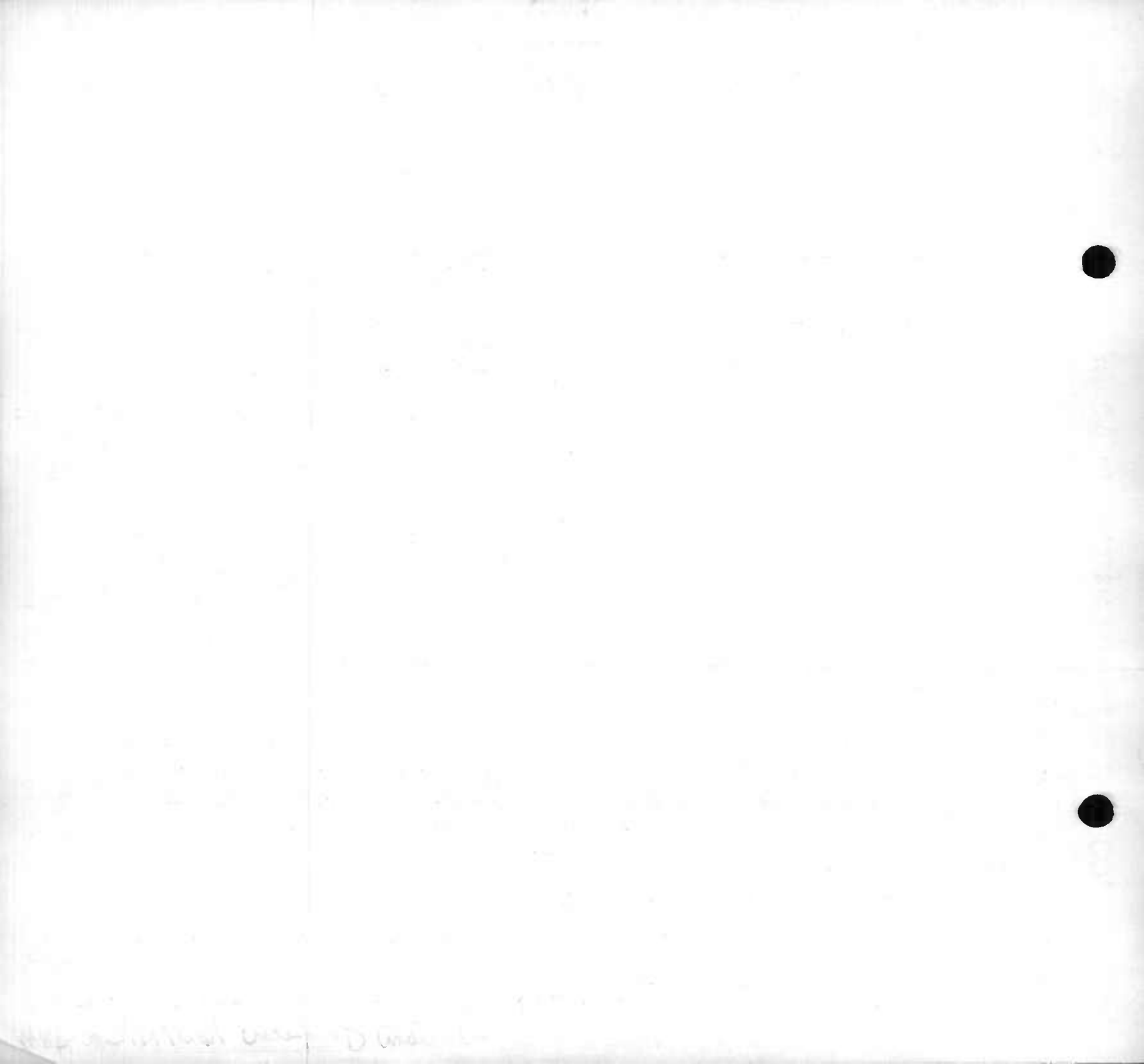
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-346 71 11363		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11363	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BESSIE BUTLER		2. DATE AND HOUR OF DEATH 12/1/71 11 15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY		5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL		E. STREET AND NUMBER 808 N. FREMONT AVE.		F. ZIP CODE 21217	
6. SEX Female	7. RACE NEGRO	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 03-16-89	10. AGE (In years last birthday) 82	11. II Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Henry Addison		14. MOTHER'S MAIDEN NAME Eleanor Pratt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-185378		17. INFORMANT John A. Butler ADDRESS Same	
18. 710.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (t) (this hospital) attended the deceased from 12/1/71 to 12/1/71 that (t) (we) last saw the deceased alive on 12/1/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (t) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Arvorance Bichairon Arong Songoran M.D. DEGREE				23B. DATE SIGNED 12/1/71	
23C. PHYSICIAN'S NAME (Type) ARVORANCE BICHAIRON ARONG SONGORAN M.D. DEGREE		23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/71		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memory	
24D. LOCATION (City, town, or county) (State) Baltimore MD.					
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Arington Schuller ADDRESS 1721 N. Mount	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

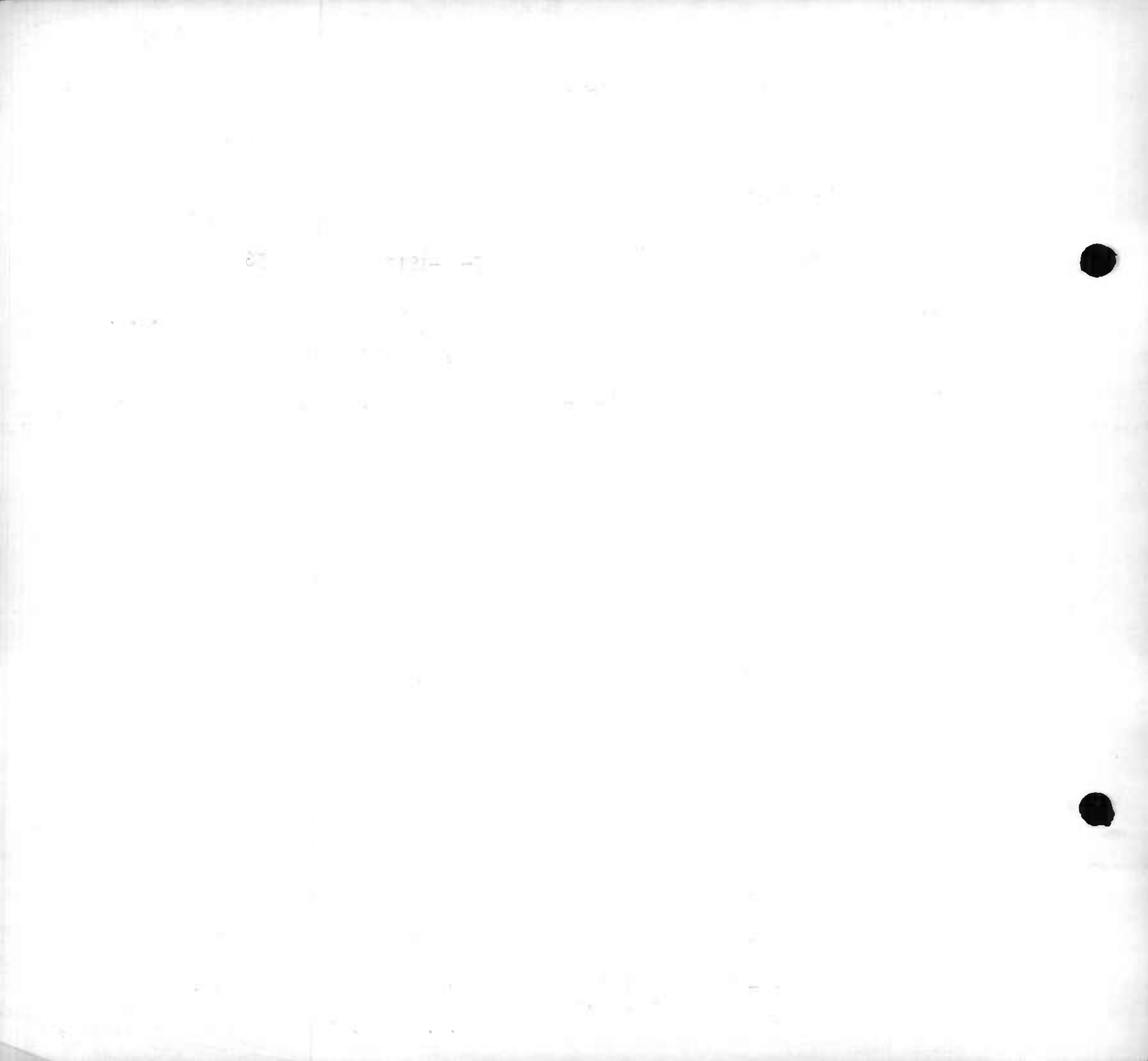
P-620 71 11364		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11364	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) PARKS, Kathleen		2. DATE AND HOUR OF DEATH 12-4-71 8:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 91 Montebello State Hosp		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MD		1204	
5. SEX F		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-9-34	
9. AOE (In years lost birthday) 37		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lynchburg VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Leonard Parks		14. MOTHER'S MAIDEN NAME Irene Lee			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Irene Cain		ADDRESS 1631 N. Milton Ave.	
18. E9431X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Recurrent Pneumonia		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Quadriplegia		(B) DUE TO, OR AS A CONSEQUENCE OF: 4 Yrs			
(C) Cord Injury, C4-5				4 Yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Neurogenic bladder				4 Yrs			
19A. DATE OF OPERATION 12-2-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of C5		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 12-04	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 408 E. North Ave. Balt. more.			
21D. TIME OF INJURY (APPROX.) 12-1-67		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Apparently from a fall			
22. I certify that (X) (this hospital) attended the deceased from 1-11-1968 to 12-4-1971 that (X) (we) last saw the deceased alive on 12-4-1971 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. J. DUREZA				23B. DATE SIGNED 12-4-71		23C. PHYSICIAN'S NAME (Type) R. J. DUREZA	
23D. ADDRESS 2908-F Glen Ave. Baltimore, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/9/71		24C. NAME OF CEMETERY OR CREMATORY MT. CARMEL	
24D. LOCATION ANNE ARONDEL CO. MD.		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR William J. Spino	
ADDRESS 1639 N. Broadway							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11365	
C-500 BIRTH NO. 71 11365		1. NAME OF DECEASED (Type or Print) CONWAY, Wesley John					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 The Johns Hopkins Hospital				2. DATE AND HOUR OF DEATH 12/2/71 1:55 p.			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundle				5. CITY OR TOWN Odenton D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. STREET AND NUMBER Waugh Chapel Road, Box 439 C				7. SEX Male 8. RACE Negro 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10B. KIND OF BUSINESS OR INDUSTRY Railroad		8. DATE OF BIRTH 5-28-1915		9. AGE (In years last birthday) 56	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Conway				14. MOTHER'S MAIDEN NAME Grace Ann Galloway			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 717-07-6711		17. INFORMANT Mrs Mary E. Conway	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ASphyxiation ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Decreased pulmonary function (C) Carcinoma (Squamous Cell) of lungs				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 12-2-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 			
22. I certify that (I) (this hospital) attended the deceased from 11/29 1971 to 12-2-71 that (I) (we) lost saw the deceased alive on 12-2-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Walter Matthew Malloy M.D.				23B. DATE SIGNED 12-2-71		23C. PHYSICIAN'S NAME (Type) Walter Matthew Malloy, M.D.	
23D. ADDRESS The Johns Hopkins Hospital				24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-6-71 24C. NAME of CEMETERY or CREMATORY Macedonia Methodist church			
24D. LOCATION Odenton (City, town, or county) A.A. Co (State) Md				25A. DATE REC'D. BY HEALTH DEPT. DEC 9 1971 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR C. E. Hicks 111 1922 Forest Drive, Anna, Md				25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11366	
L-200 71 11366					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LEAKE, CHARLES LOVELL		DECEMBER 5, 1971 7:15A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		MARYLAND BALTIMORE 21228			
		C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		E. STREET AND NUMBER 2009 ROCKWELL AVE.		5300	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 20 20	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICE MANAGER		10B. KIND OF BUSINESS OR INDUSTRY COVERALL UNIFORM &		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CARLTON LEAKE		14. MOTHER'S MAIDEN NAME NELLIE (POTTER)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-12-3263		17. INFORMANT WILKENS AVES. BALTO. MD. ST. AGNES HOSPITAL RECORDS-CATON &	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute MI Causing Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: → Possibly Massive Brain damage (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Aortic insuff and stenosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 2 19 71 to DECEMBER 5 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 5 19 71 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) XXXX view the body after death.					
23A. SIGNATURE Rahman Karimi MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/5/71	
23C. PHYSICIAN'S NAME (Type) RAHMAN KARIMI MD		23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 8, 1971		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION Balto. Md.		24E. FUNERAL DIRECTOR G. Truman Schwab			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR John E. Fisher		25C. ADDRESS 5151 Balto. Nat. Pk	

11:10 AM, 11/11/11

11:10 AM, 11/11/11

11:10 AM, 11/11/11

ST. AGNES HOSPITAL

11:10 AM, 11/11/11

11:10 AM, 11/11/11

11:10 AM, 11/11/11

11:10 AM, 11/11/11

11:10 AM, 11/11/11

11:10 AM, 11/11/11

11:10 AM, 11/11/11

11:10 AM, 11/11/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11367	
CERTIFICATE OF DEATH			
BIRTH NO. M-524		71 11367	
1. NAME OF DECEASED (Type or Print) LULA F. MENZEL		2. DATE AND HOUR OF DEATH Dec. 2, 1971 5 p. <small>M.</small>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Longreen Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 21224 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 418 N. Curley Street	
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Miss Casset	9. AGE (In years last birthday) 84
13. FATHER'S NAME Peter C. Menzel		14. MOTHER'S MAIDEN NAME Mary J. Riebel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 219-01-3576		16. SOCIAL SECURITY NO. 219-01-3576	
17. INFORMANT Margaret V. Armstrong, neice, above		ADDRESS	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterior sclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 July 71	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8 July 19 71 to 2 December 19 71 that (I) (we) last saw the deceased alive on 2 December 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John W. Barnaby		23B. DATE SIGNED 3 Dec 71	
23C. PHYSICIAN'S NAME (Type) Dr. John W. Barnaby		23D. ADDRESS 1652 E. Belvedere Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/6/71	24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971	25B. NAME OF REGISTRAR Robert E. Vasey, M.D.	25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460 71 11368		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11368	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ruth E Miller</i>		2. DATE AND HOUR OF DEATH <i>12/3/71 7:45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>841</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital.</i> <i>33</i>		C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Caucasian</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. City</i>		8. DATE OF BIRTH <i>8/28/27</i>	
13. FATHER'S NAME <i>Wm. W. Wright</i>		14. MOTHER'S MAIDEN NAME <i>Annie -</i>		9. AGE (in years last birthday) <i>44</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
17. INFORMANT <i>Adam Miller (husband) same address</i>		ADDRESS		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>182.014230.9</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Recurrent Endometrial Carcinoma</i> (B) <i>Recurrent Endometrial Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>None</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>None</i>	
21D. TIME OF INJURY (APPROX.) <i>None</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>None</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>11/30</i> 19 <i>71</i> to <i>12/3</i> 19 <i>71</i> that (I) (we) lost saw the deceased alive on <i>12/2</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles B. Martz</i>		23B. DATE SIGNED <i>12/3/71</i>		23C. PHYSICIAN'S NAME (Type) <i>Charles B. Martz</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12/6/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 9 1971</i>		25B. NAME OF REGISTRAR <i>Ruth E. Miller</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto Md 21213</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11369	
G-625 71 11369		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) GEORGE W. GRASMICK		2. DATE AND HOUR OF DEATH December 2nd, 1971 8:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 602	
FULL NAME OF HOSPITAL OR INSTITUTION 44 CERTIFICATE AMENDED Union Memorial Hospital 1-19-72		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 2617 E. FAIRMOUNT AVE.	
8. DATE OF BIRTH 03/28/1897 9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Mgr.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Grasmick		14. MOTHER'S MAIDEN NAME Theresa Steigerwald	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 213-03-2470	
17. INFORMANT Mildred Grasmick (wife) same address		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of the prostate - metastatic Respiratory Arrest Beau Metastases Intestinal Cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Uremia, Renal Failure			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
21A. DATE OF OPERATION 11/17/1971 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Prostate - Large Bowel Obstruction		22A. AUTOPSY? (Yes or No) No	
21C. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21D. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21E. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-10-71 to 12-2nd-71 and that (I) (we) last saw the deceased alive on 12-2nd-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED December 2nd, 1971	
23C. PHYSICIAN'S NAME (Type) RONALDO S. CARNEIRO		23D. ADDRESS 33rd & Calvert Sts. - Balto. Md	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/4/71	
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Schmucker Funeral Homes, Inc.		25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213	

1-19-72 - Letter from - The Union Memorial Hospital.
Theresa M. Winter, RRA
Director, Medical Records

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11370	
W-436 71 11370 BIRTH NO. 1. NAME OF DECEASED (Type or Print) WALTROP, MR. WILLIAM G.		2. DATE AND HOUR OF DEATH 12-3-71 8:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 Keswick 700 W. 40th Street #11		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2652 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4854 Bowland Avenue			
5. SEX M 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-19-1884 9. AGE (In years last birthday) 87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O Railroad		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME William Waltrop			
14. MOTHER'S MAIDEN NAME Kane Anna Sparrow		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 705-12-3636		17. INFORMANT ADDRESS Keswick Medical Records			
18. 486 X I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. (It means the disease, injury or complication which caused death.) Pneumonia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Encephalomalacia, severe, secondary to cerebral arteriosclerosis				(B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Oct 6 1971 to Dec 3 1971 that (2) (we) last saw the deceased alive on Dec. 3 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W.B. DANIELS, Jr. M.D.				23B. DATE SIGNED 12-3-71	
23C. PHYSICIAN'S NAME (Type) W.B. DANIELS, Jr. M.D.				23D. ADDRESS Keswick	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/6/71		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Bal to. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971			
25B. NAME OF REGISTRAR Robert E. Varley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md 21213			

V.S. 153

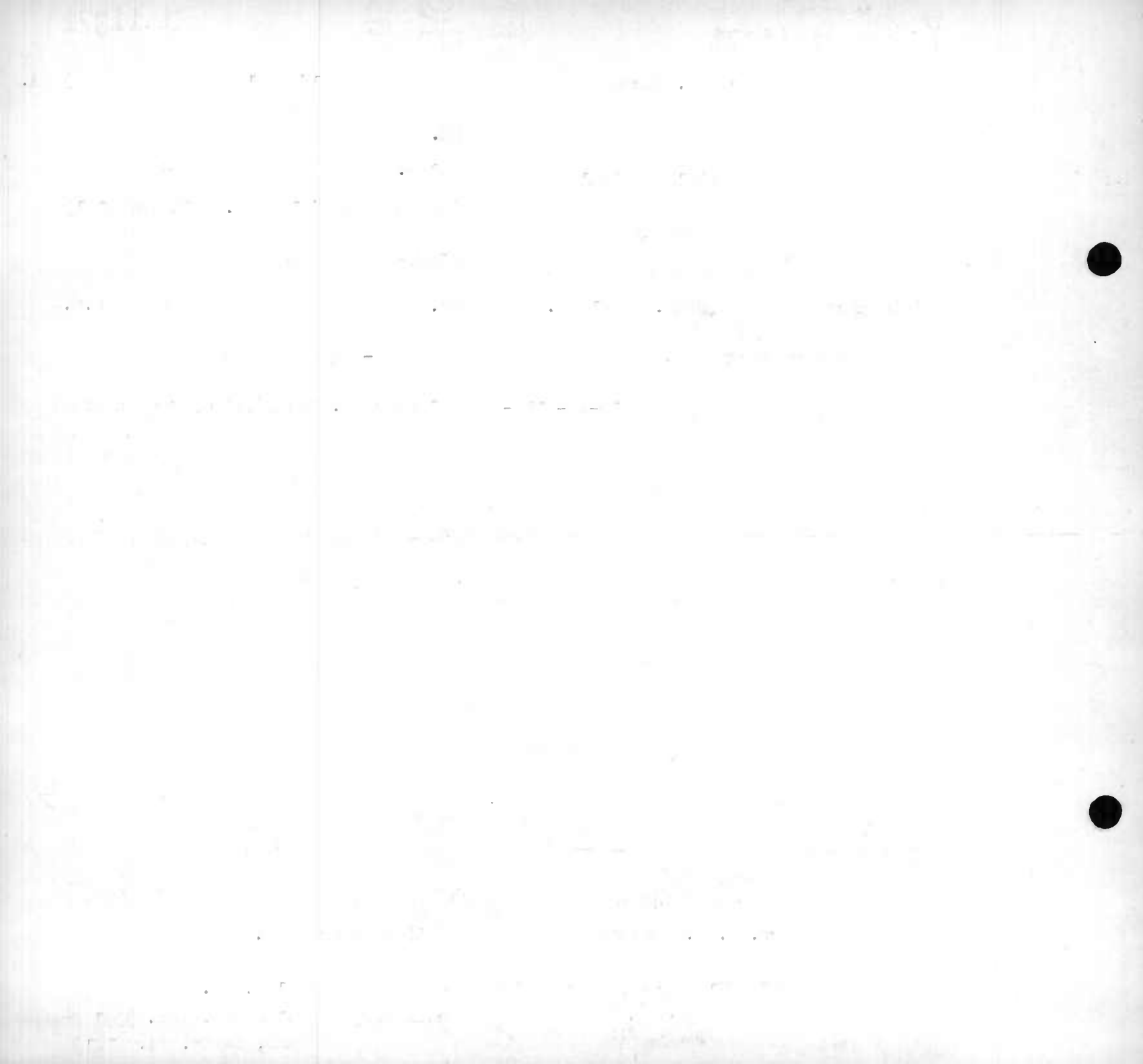
12-20-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11371	
<div style="display: flex; justify-content: space-between;"> V-22071 11371 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) George W. Vacek			2. DATE AND HOUR OF DEATH 12/5/71 3 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2643		
			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3660 Chesterfield Ave. Balto Md 21213		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/05	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Jerome Vacek			
14. MOTHER'S MAIDEN NAME -		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 213-07-2110-A		17. INFORMANT Florence E. Vacek (wife) same address			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease Coronary Insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/11 19 65 to 12/5 19 71 , that (I) (we) last saw the deceased alive on 10/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE L B Stevens			23B. DATE SIGNED 12/6/71		23C. PHYSICIAN'S NAME (Type) Dr. L. B. Stevens
23D. ADDRESS 3400 Erdman Ave.			23E. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/9/71		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-615 71 11372				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. [REDACTED]	
1. NAME OF DECEASED (Type or Print) EUGENE GARFINKEL				2. DATE AND HOUR OF DEATH DECEMBER 4, 1971 17:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2740			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL OF BALTIMORE				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5857 A WESTERN RUN RD. #9			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/28/11	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEERING DEPT. SINAI				11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XXXXXXXXX SAMUEL GARFINKEL				14. MOTHER'S MAIDEN NAME XXXXXXXXX IDA POTTS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-1078947		17. INFORMANT Mrs. Saul Carmel, 6507 Delbrook Rd. #9	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO-PULMONARY ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HEPATIC COMA				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HEPATIC COMA		FEW DAYS	
				(B) DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA OF PANCREAS		FEW WEEKS	
				(C) METASTASIS			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 11/2 & 11/8 '71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LARGE CARCINOMA OF PANCREAS		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from OCT. 26, 1971 to DEC. 4, 1971 that (I) (we) last saw the deceased alive on OCT. 4, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Cayetano T. Dizon, M.D.				23B. DATE SIGNED DEC. 4, 1971		23C. PHYSICIAN'S NAME (Type) CAYETANO T. DIZON, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-5-71		24C. NAME OF CEMETERY OR CREMATORY BETH HAMEDROSH HAGODOL		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

~~SECRET~~

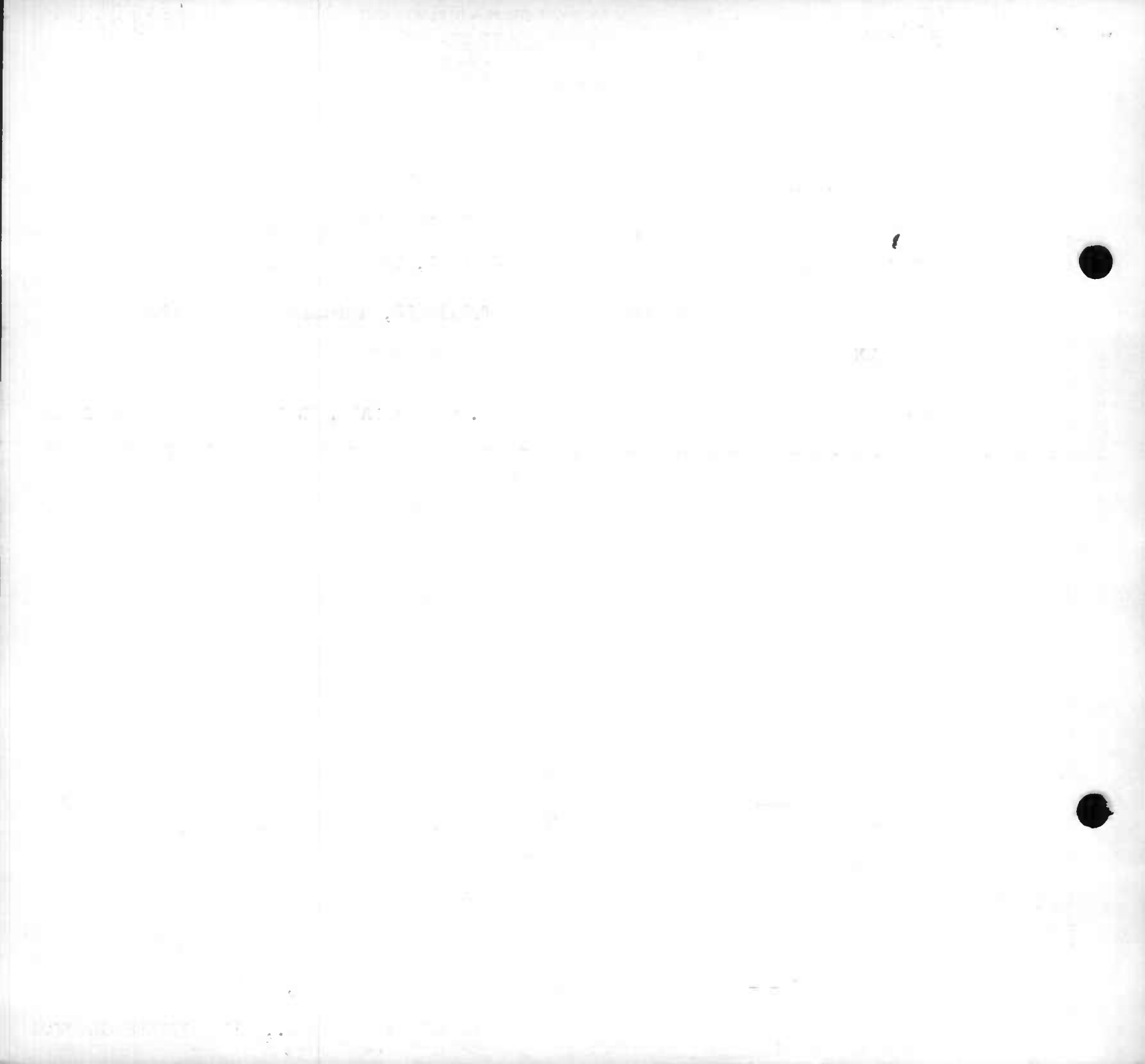
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SECRET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

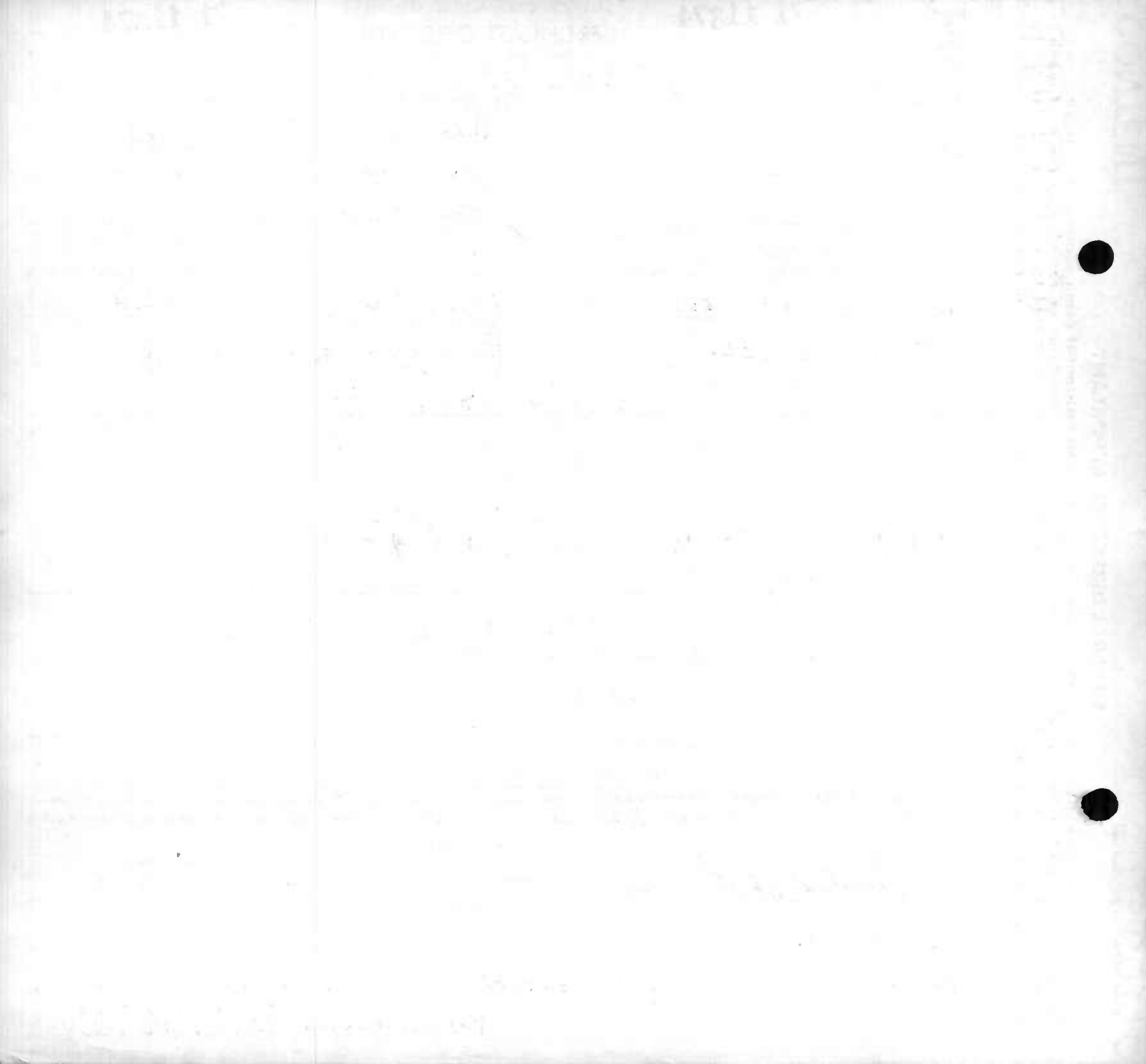
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11373
L-100 71 11373				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SARAH LAFF		2. DATE AND HOUR OF DEATH Dec. 4, 1971 1 AM M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2730		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3507 LABYRINTH ROAD		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 27, 1906	9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. HERMAN LAFF, 3507 LABYRINTH ROAD #21215
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic Heart Disease		1 year
		(B) DUE TO, OR AS A CONSEQUENCE OF: None		
		(C) None		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Dec 3, 1971 to Dec 4, 1971 that (I) (we) lost saw the deceased alive on Dec 4, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Manuel Levin M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/4/71
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN M.D.		23D. ADDRESS 6101 PARK HIGHS AVE, BALD-15 MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12-5-71	24C. NAME of CEMETERY or CREMATORY AGUDAS BNAI JACOB LODGE	24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971	25B. NAME OF REGISTRAR Robert E. Scales, M.D.	25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

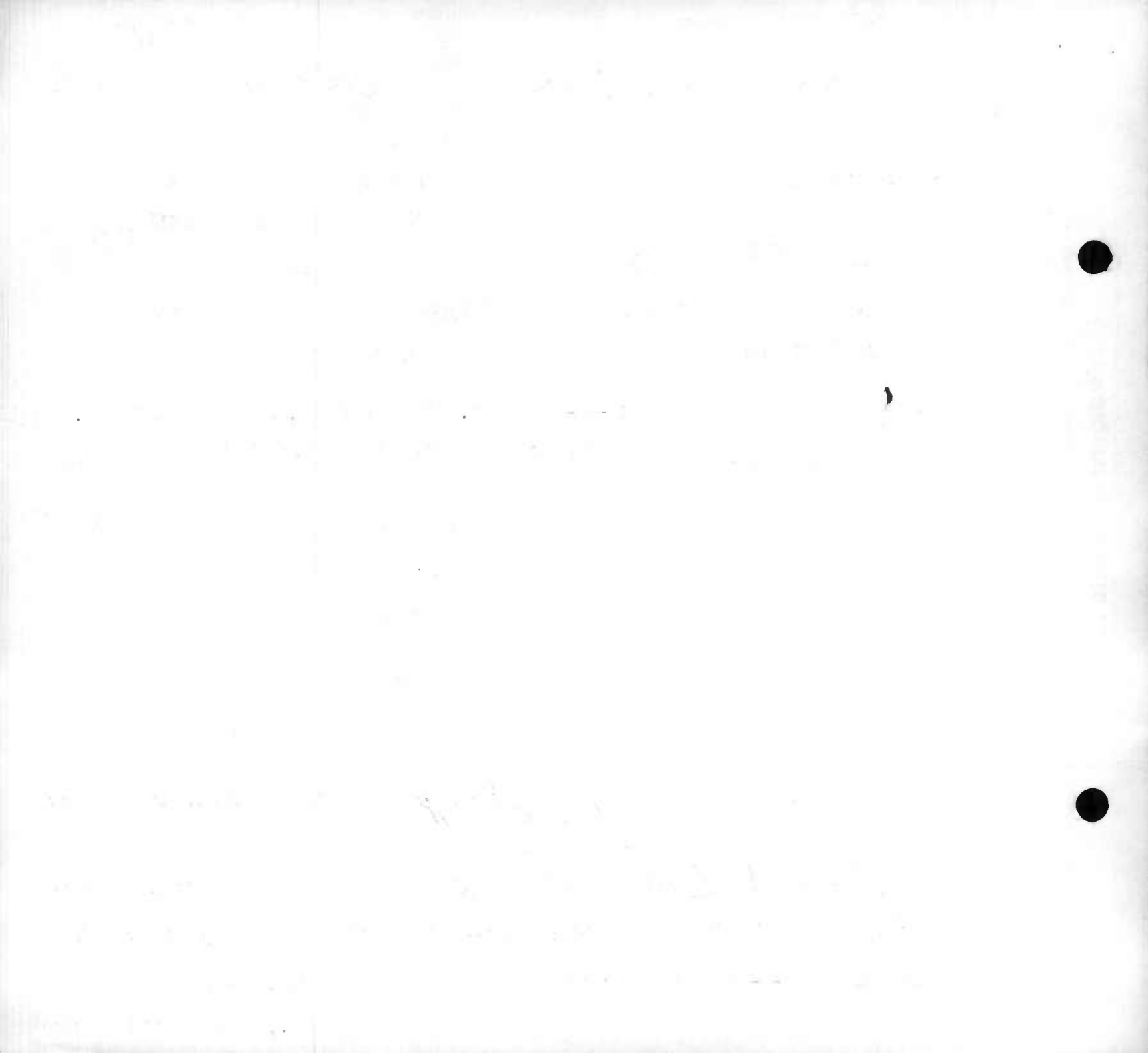
Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 71 11374	
BIRTH NO. 7-524		71 11374					
1. NAME OF DECEASED (Type or Print) <u>SR. M. CATHERINE FENZEL, SSND</u>				2. DATE AND HOUR OF DEATH <u>12-4-71</u> <u>7:50</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u> <u>Mercy Hospital</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>MARYLAND</u>		B. COUNTY <u>1002</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>901 ALBANY ST.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-99</u>		9. AGE (In years last birthday) <u>72</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSIC TEACHER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION</u>		11. BIRTHPLACE (State or foreign country) <u>BALT. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>HENRY FENZEL</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH KREKENHOFER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-54-9327</u>		17. INFORMANT <u>CONVENT RECORDS</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>038.9</u> <u>CEREBROVASCULAR ACCIDENT</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>UTI, Paget's disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <u>Dec 3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Benedict A. Termini</u>				23B. DATE SIGNED <u>12/4/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Benedict A. Termini</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-7-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>SISTERS CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>GLEN ARM, BALT., MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1971</u>		25B. NAME OF REGISTRAR <u>James M.D.</u>		25C. FUNERAL DIRECTOR <u>RAYMOND J. CURRAN</u>			
ADDRESS <u>817 SCARLETT DR. TOWSON, MD 21204</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>S-351 71 11375</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 11375</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) ROSE STOMBLER</p>		<p>2. DATE AND HOUR OF DEATH DEC 5, 1971 9²⁵ A M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42</p> <p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2717</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 3313 AVONDALE AVENUE #21215</p>	
<p>5. SEX FEMALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 60 9. AGE (In years last birthday) 60</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY AT HOME</p>	
<p>11. BIRTHPLACE (State or foreign country) POLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME ABRAHAM STEINBERG</p>		<p>14. MOTHER'S MAIDEN NAME ANNA ?</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. 219-05-6626</p>	
<p>17. INFORMANT MRS. SARA MELNIKOFF, 3505 DEVONSHIRE DR. #21215</p>		<p>ADDRESS</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 410.9 I Acute myocardial Infarction</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: None (C) DUE TO, OR AS A CONSEQUENCE OF: None</p>	
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) no</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from Dec 4 1971 to Dec 6 1971 that (I) (we) last saw the deceased alive on Dec 5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Manuel Levin M.D.</p>		<p>23B. DATE SIGNED Dec 5, 1971</p>	
<p>23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN M.D.</p>		<p>23D. ADDRESS 6101 PARK HILLS AVE BALD-15 MD.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>		<p>24B. DATE 12-6-71</p>	
<p>24C. NAME of CEMETERY or CREMATORY HEBREW YOUNG MEN</p>		<p>24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Fisher, M.D.</p>	
<p>25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</p>		<p>ADDRESS</p>	



FUNERAL DIRECTOR: IMPORTANT

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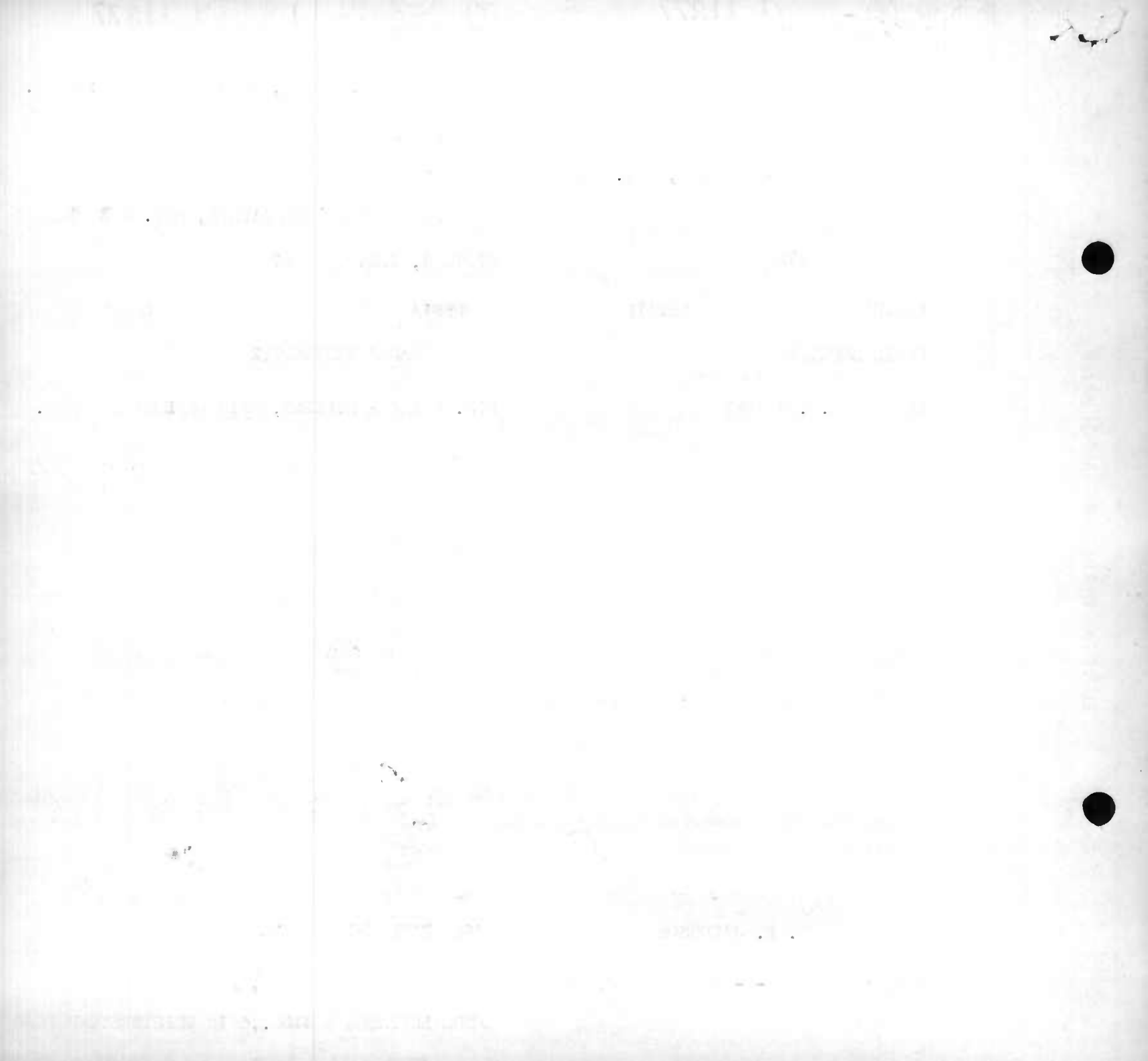
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 11376</u>	
1. NAME OF DECEASED (Type or Print) <u>SPIEWAK HENRY</u>				2. DATE AND HOUR OF DEATH <u>3 DEC 71</u> <u>11:00 A. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE [Where deceased lived. If institution: residence before admission] A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> CITY <u>5300</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>GOOD SAMARITAN HOSPITAL</u> <u>45</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>6913 BLANCHE RD.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-02-23</u>	9. AGE (in years last birthday) <u>48</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXXXXXXXX</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>INTERIOR DECORATOR</u> <u>SELF-EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>XXXXXXXXXXXX LAIB SPIEWAK</u>				14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXXXX ROSA ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-38-308</u>		17. INFORMANT <u>MRS. JULIA SPIEWAK, 6913 BLANCHE ROAD #21215</u> <u>XXXXXX (4E, above)</u>		ADDRESS	
18. <u>582X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CEREBRO VASCULAR</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ACCIDENT</u> (B) <u>ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CHRONIC RENAL FAILURE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>28 DAYS</u> <u>3 YEARS</u> <u>6 YEARS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>				<u>REJECTED RENAL TRANSPLANT 2 YEARS</u>			
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>26 NOV</u> 19 <u>71</u> to <u>3 DEC</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>3 DEC</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William D. Hillis M.D.</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3 DEC 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>William D. Hillis M.D.</u> DEGREE				23D. ADDRESS <u>GOOD SAMARITAN HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5 DEC 71</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1971</u>		25B. NAME OF REGISTRAR <u>BALTO. HEALTH DEPT.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11377	
BIRTH NO. H-125					
1. NAME OF DECEASED (Type or Print) DAVID HOPKINS			2. DATE AND HOUR OF DEATH DECEMBER 5, 1971 3:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6310 GREENSPRING AVENUE, APT. 408 00			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6310 GREENSPRING AVENUE, APT. 408 #21209		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH APRIL 4, 1904	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME EDWIN HOPKINS			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I ARMY			16. SOCIAL SECURITY NO.		
			17. INFORMANT MRS. FRANCES HOPKINS, 6310 GREENSPRING AVE.		
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Lung (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dec 1970		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 22, 1963 to Dec 5, 1971 , that (I) (we) last saw the deceased alive on Dec. 5, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. W. JACOBSON			23B. DATE SIGNED 12-6-71		
23C. PHYSICIAN'S NAME (Type) M. W. JACOBSON			23D. ADDRESS 6810 PARK HEIGHTS AVENUE		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-6-71		24C. NAME OF CEMETERY or CREMATORY BETH JACOB	
		24D. LOCATION (City, town, or county) (State) FINKSBURG, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 11378</p>	
<p>7-360 71 11378</p> <p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) FEDDER, William</p>	
<p>2. DATE AND HOUR OF DEATH 12/4/71 11:15 A.M.</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived, if institutions: residence before admission) A. STATE MD. B. COUNTY BALTO.</p>		<p>5. SEX MALE 6. RACE CAUCASIA</p>	
<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 11/07/1894 9. AGE (in years last birthday) 77</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED</p>	
<p>11. BIRTHPLACE (State or foreign country) RUSSIA</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME JOSEPH FEDDER</p>		<p>14. MOTHER'S MAIDEN NAME NAOMI KLEINMAN</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. 214-30-7313</p>	
<p>17. INFORMANT MRS. ROSE FEDDER, 3016 NORTHBROOK ROAD #21209</p>		<p>ADDRESS</p>	
<p>18. CAUSE OF DEATH</p> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE CHRONIC CONGESTIVE HEART FAILURE</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) CHRONIC BRAIN SYNDROME</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>YEARS</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 12/4 1971 to 12/4 1971 and that (I) (we) lost saw the deceased alive on 12/4 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p>DAVID GLASER, M.D.</p>		<p>23B. DATE SIGNED 12/4/71</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>		<p>23D. ADDRESS SINAI HOSP. OF BALTO</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>		<p>24B. DATE 12-6-71</p>	
<p>24C. NAME of CEMETERY or CREMATORY BETH TFILOH</p>		<p>24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</p>	
<p>25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</p>		<p>ADDRESS</p>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11379
1. NAME OF DECEASED (Type or Print) Herbert W. Norris		2. DATE AND HOUR OF DEATH 12/6/71 5:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 2122 4940 Eastern Avenue Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1535 Wesper Ave 21222		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/82	9. AGE (In years last birthday) 89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboren		10B. KIND OF BUSINESS OR INDUSTRY PAINTING		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANCIS NORRIS		
14. MOTHER'S MAIDEN NAME ELIZABETH STEVENS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-46-5202JT		17. INFORMANT 4940 Eastern Avenue ADDRESS BCH:Records Baltimore, Maryland 21224		
18. 427.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Possible Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF: (B) Atrial Fibrillation, Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). MEDICAL CERTIFICATION				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11-30 19 71 to 12-6 19 71 that (I) (we) last saw the deceased alive on 12-6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Lee R. Barker, Jr.		23B. DATE SIGNED 12/6/71		23C. PHYSICIAN'S NAME (Type) LEE - R. BARKER
23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 12/9/71		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		24D. LOCATION (City, town, or county) (State) BALTO., MD.
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John A. Miller ADDRESS 2334 Jefferson

Elizabeth G. Stevens
My Dear Mr.

Friend

Dear Mr.

—

Yours truly,

John P. Jones

1871

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		71 11380		BALTIMORE CITY HEALTH DEPARTMENT		71 11380	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) LILLIAN ROBERTA LONES				2. DATE AND HOUR OF DEATH 12/8/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL				A. STATE MD.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTO. MD. 21216				B. COUNTY		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1455 MONTGOMERY CT. 21216	
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-19-18	9. AGE (in years last birthday) 53	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER			11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM A. SORRELL			14. MOTHER'S MAIDEN NAME HELENA BUTLER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT WILLIAM JONES		
			ADDRESS 5702 RUBINAK				
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIAC ARREST ACUTE CORONARY				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ISCVD							
19A. DATE OF OPERATION 12/8/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/8/71 to 12/8/71 and that (I) (we) last saw the deceased alive on 12/8/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE RAYOSO				23B. DATE SIGNED 12/8/71			
23C. PHYSICIAN'S NAME (Type) ELMO MOSCOSO GAYOSO				23D. ADDRESS LUTHERAN HOSP. 21216			
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 12-11-71		24C. NAME OF CEMETERY OR CREMATORY CARVER MEM. PARK		24D. LOCATION (City, town, or county) (State) LAUREL MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wesley Chavis Jr.		ADDRESS 1922 Edmondson Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-4001

71 11381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11381

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Thomas I. Gill		Nov. 26, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3504 Roland Ave.				A. STATE Md.	
				B. COUNTY	
				C. CITY OR TOWN Balto.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3504 Roland Ave.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 6, 1892	79	Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Railway X.		Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
?			?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		714-05-6688		Beatrice W. Gill	
				Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.414162.1 CAUSE OF DEATH Asent (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				2 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sheldon Hedger				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/30/71		Pleasant Grove	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 9 1971		Paul E. Taylor, M.D.		Paul E. Chenoweth 3rd. 3617 Chestnut Ave.	

1861

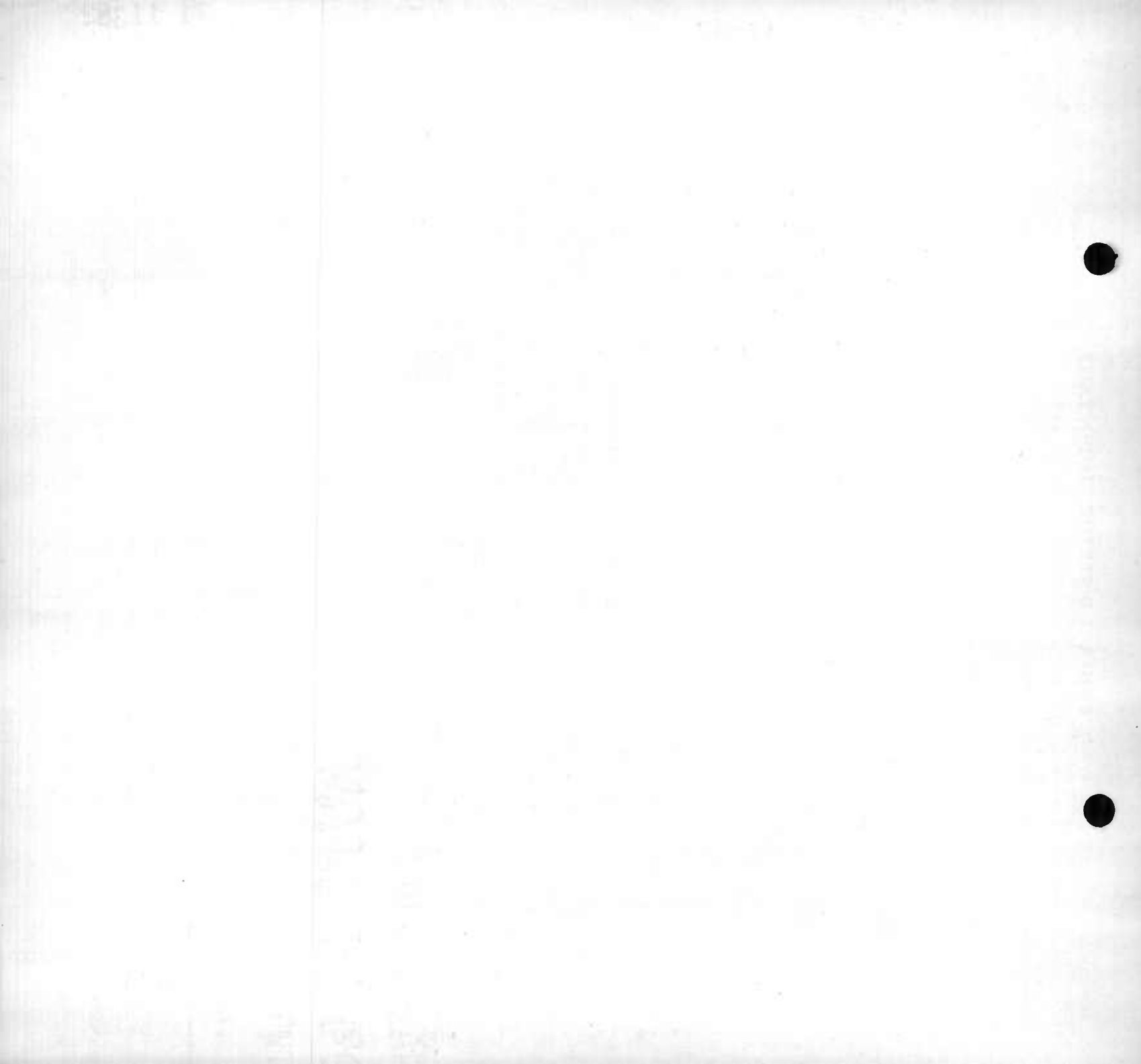
1861



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11382 4	
CERTIFICATE OF DEATH					
BIRTH NO. 71-19680		1. NAME OF DECEASED (Type or Print) BABY GIRL HAWKINS			
2. DATE AND HOUR OF DEATH 11-18-71		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 SINAI HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1512		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL			
6. CITY OR TOWN Baltimore		7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
8. STREET AND NUMBER 2913 Keyworth Ave.					
9. SEX FEMALE	10. RACE BLACK	11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. DATE OF BIRTH 11-18-71	13. AGE (In years last birthday) 30	14. If Under 1 Yr. Months: Days: Hours: Min.
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY		17. BIRTHPLACE (State or foreign country)	
18. FATHER'S NAME William S. S.		19. MOTHER'S MAIDEN NAME PATRESE HAWKINS		20. CITIZEN OF WHAT COUNTRY?	
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		22. SOCIAL SECURITY NO.		23. INFORMANT PATRESE HAWKINS	
24. ADDRESS 2913 KEYWORTH AVE.					
25. CAUSE OF DEATH 18. 776.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Primary angina ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Immaturity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
27. DATE OF OPERATION 0		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No)	
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
33. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. HOW DID INJURY OCCUR?	
36. I certify that (I) (this hospital) attended the deceased from 11-18-71 to 11-18-71 , that (I) (we) last saw the deceased alive on 11-18-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
37. SIGNATURE Isabelo Mascardo		38. DATE SIGNED November 29, 1971		39. PHYSICIAN'S NAME (Type) MD DEGREE	
40. BURIAL CREMATION, REMOVAL (Specify)		41. DATE 12-8-71		42. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
43. DATE REC'D BY HEALTH DEPT. DEC 9 1971		44. NAME OF REGISTRAR Robert E. Kelly, M.D.		45. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]	
S-536 71 11383		71 11383	
BIRTH NO. 71-193604		DATE AND HOUR OF DEATH 11/26/71 3:25 P.M.	
1. NAME OF DECEASED (Type or Print) Baby Boy Saunders		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE Inc. 42		A. STATE Maryland B. COUNTY 27-16	
		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4637 Park Hgts.	
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 10
		11. BIRTHPLACE (State or foreign country) SINAI HOSP. OF BALTO.	12. CITIZEN OF WHAT COUNTRY? MD
13. FATHER'S NAME ALFRED THORNTON SAUNDERS		14. MOTHER'S MAIDEN NAME EVELYN SAUNDERS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS	
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/17 1971 to 11/26 1971 that (I) (we) last saw the deceased alive on 11/26 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Anchalet MD		23B. DATE SIGNED 11/26/71	
23C. PHYSICIAN'S NAME (Type) ANCHALET		23D. ADDRESS MD ANATOMY BOARD OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) 12-8-71		24B. DATE	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
MORTUARY SERVICE - BCHD			

8-3-54

2.526

11/26/71

Body Bag Number

21002

Wardland

Boatman

3101 HOSPITAL OF BALTIMORE

3037 Post Hq

11/17/71

M

M

10

M

3101 HOSP. OF BALTO.

EVERIN

DAVID SANDERS

10 days

Presumptive

18

11/26

15

11/17

11/26

MD

MD

ANCHUTER
Anchor

11/26/71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-36371-11384		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11384	
BIRTH NO. 71-11384		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Boy Edwards</i>		2. DATE AND HOUR OF DEATH <i>11/23/71 1:20 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Sinai Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>male</i>		6. RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11-21-71</i>		9. AGE (in years last birthday) <i>3</i>		10. UNDER 1 Yr. Months <i>3</i> Days <i>3</i> Hours <i>3</i> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Unknown</i>			
14. MOTHER'S MAIDEN NAME <i>Aquasetta Edwards</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <i>485X1</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Bilateral bronchopneumonia</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Aspiration</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>12/21</i> 1971 to <i>11/23</i> 1971		that (H) (we) last saw the deceased alive on <i>11/23</i> 1971 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did not) view the body after death.			
23A. SIGNATURE <i>A. Dingcong, M.D.</i>		23B. DATE SIGNED <i>11/23/71</i>		23C. PHYSICIAN'S NAME (Type) <i>A. Dingcong, M.D.</i>	
23D. ADDRESS <i>Sinai Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify)			
24B. DATE <i>12-8-71</i>		24C. NAME OF CEMETERY OR CREMATOR		24D. LOCATION (City, town, or county) (State)	
25A. DATE REG'D BY HEALTH DEPT. <i>DEC 9 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-452		71 11385		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11385	
1. NAME OF DECEASED (Type or Print) BABY GIRL WILLIAMS (JOAN)				2. DATE AND HOUR OF DEATH 11-27-71 12 20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hosp. of Balto., Inc (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3800 SEQUOIA AVE 21215			
5. SEX Female	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27-71	9. AGE (In years lost birthday) NEWBORN	10. CITIZEN OF WHAT COUNTRY? If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 1 35	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME LESLIE C. WILLIAMS				14. MOTHER'S MAIDEN NAME JOAN C.A. DORSEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT DR. MICHAEL		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 769.0 CAUSE OF DEATH immaturity (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: incompetent internal ceroid (B) DUE TO, OR AS A CONSEQUENCE OF: (C)..... II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from BIRTH 10:45 AM 11/27/1971 to DEATH 12:20 P 11/27/1971 , that (I) (we) last saw the deceased alive on 11-27-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Herold H. Michael, M.D.				23B. DATE SIGNED 11-27-71		23C. PHYSICIAN'S NAME (Type) HEROLD H. MICHAEL, M.D.	
24A. BURIAL CREATION, REMOVAL (Specify)		24B. DATE 12-8-71		24C. NAME OF CEMETERY or CREMATOR ANATOMY BOARD OF MARYLAND		24D. LOCATION (State)	
25A. DATE RECD BY HEALTH DEPT. DEC 9 1971				25B. NAME OF REGISTRAR John E. Taylor, Jr.			

RECEIVED

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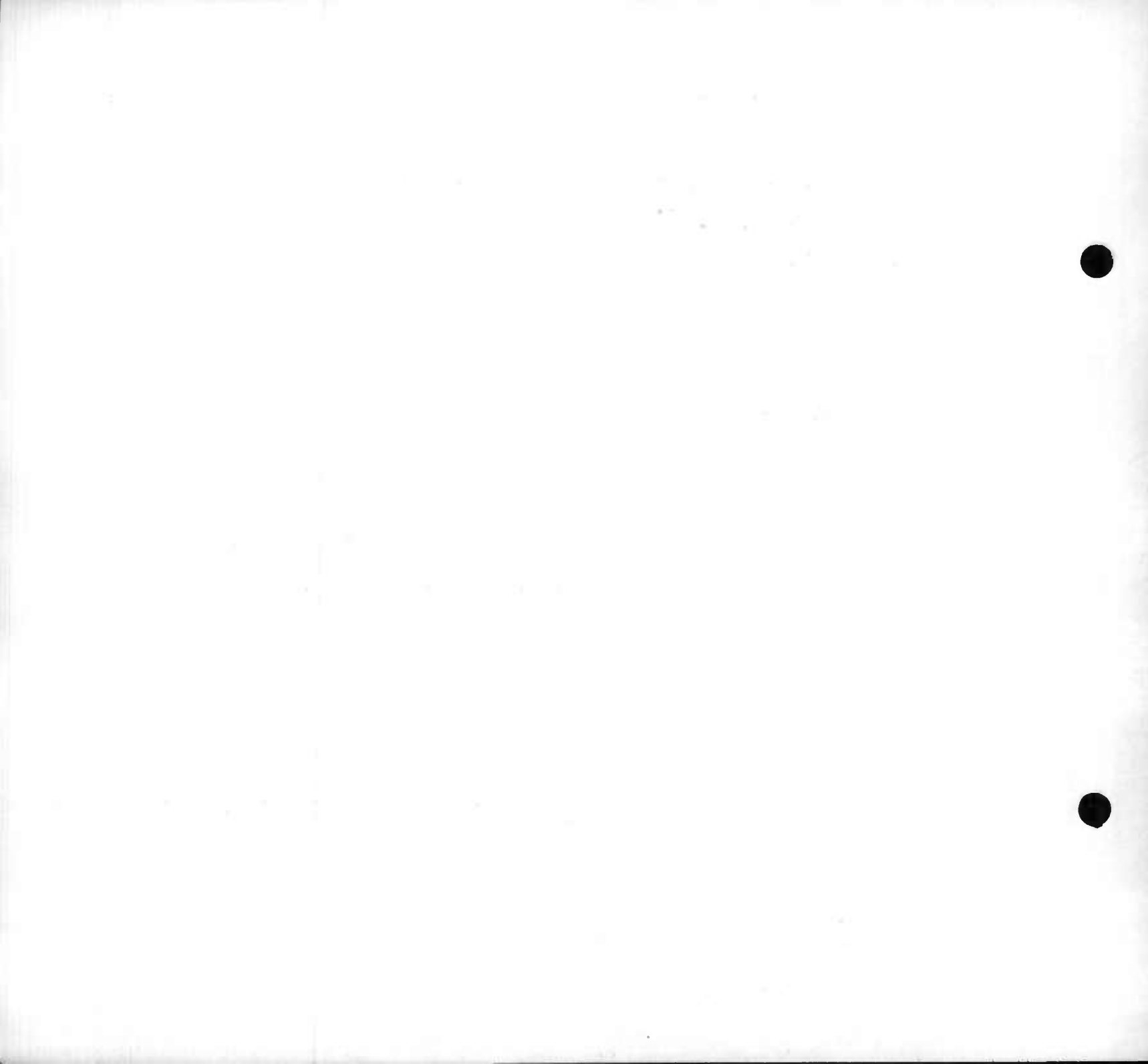
RECEIVED

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

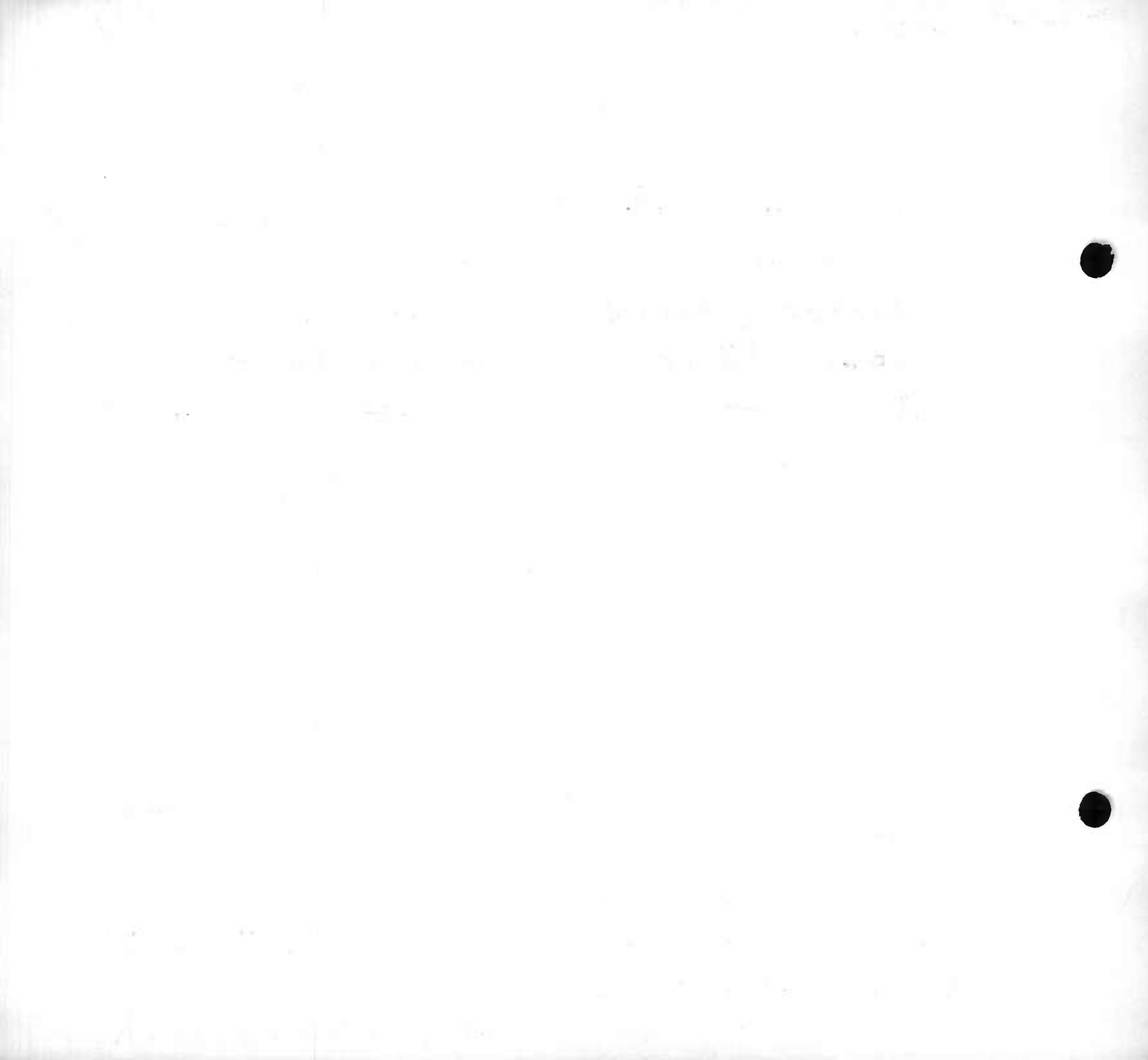
<p>P-325 71 11386</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 11386</p>	
<p>1. NAME OF DECEASED (Type or Print) <u>Pudkindki, George</u></p>		<p>2. DATE AND HOUR OF DEATH <u>11/17/71</u> <u>8:00</u> <u>P</u> <u>M.</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1510</u></p>	
<p>5. SEX <u>Male</u></p>		<p>6. RACE <u>White</u></p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>72</u></p>	
<p>9. AGE (In years last birthday) <u>72</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>	
<p>11. BIRTHPLACE (State or foreign country)</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME</p>		<p>14. MOTHER'S MAIDEN NAME</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u></p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT</p>		<p>ADDRESS</p>	
<p>18. CAUSE OF DEATH <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>(A) IMMEDIATE CAUSE <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>(B) <u>Myocardial CVA</u> <u>G. spirillum</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u></p>	
<p>(C) <u>Gastrointestinal</u> <u>Bleeding</u></p>		<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>November 14</u> 19 <u>71</u> to <u>November 17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>November 17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>William J. Lutz M.D.</u></p>		<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>		<p>24B. DATE <u>12-8-71</u></p>	
<p>24C. NAME of CEMETERY or CREMATOR</p>		<p>24D. LOCATION (City, town, or county) (State)</p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p>		<p>25B. NAME OF REGISTRAR</p>	
<p>25C. FUNERAL DIRECTOR</p>		<p>25D. MORTUARY SERVICE</p>	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-200		71 11387		71 11387	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Irene Hussey		12/6/71		6 15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED/DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
31 Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md. 21224		Md.		2610	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		334 S. Highland Ave		21224	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years lost birthday)	10. If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
Female	Caucasian White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9-9-1896	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Packer		Retired		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Lewis Miller		Katherine -		U. S. A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		217-32-7938		Records: BCH-4940 Eastern Ave., 21224	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		7 month	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		YES	YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 1113 19 71 to 12/6/19 71 that (I) (we) lost saw the deceased alive on 12/6/19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Ronald Banks M.D.		12/6/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Ronald Banks M.D.		4940 Eastern Ave., Baltimore, Md 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	12/8/71	Oaklawn Cem		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
DEC 9 1971	Robert F. Taylor, M.D.	Joseph N. Zanning		263 S. Conkling	



FUNERAL DIRECTOR: IMPORTANT

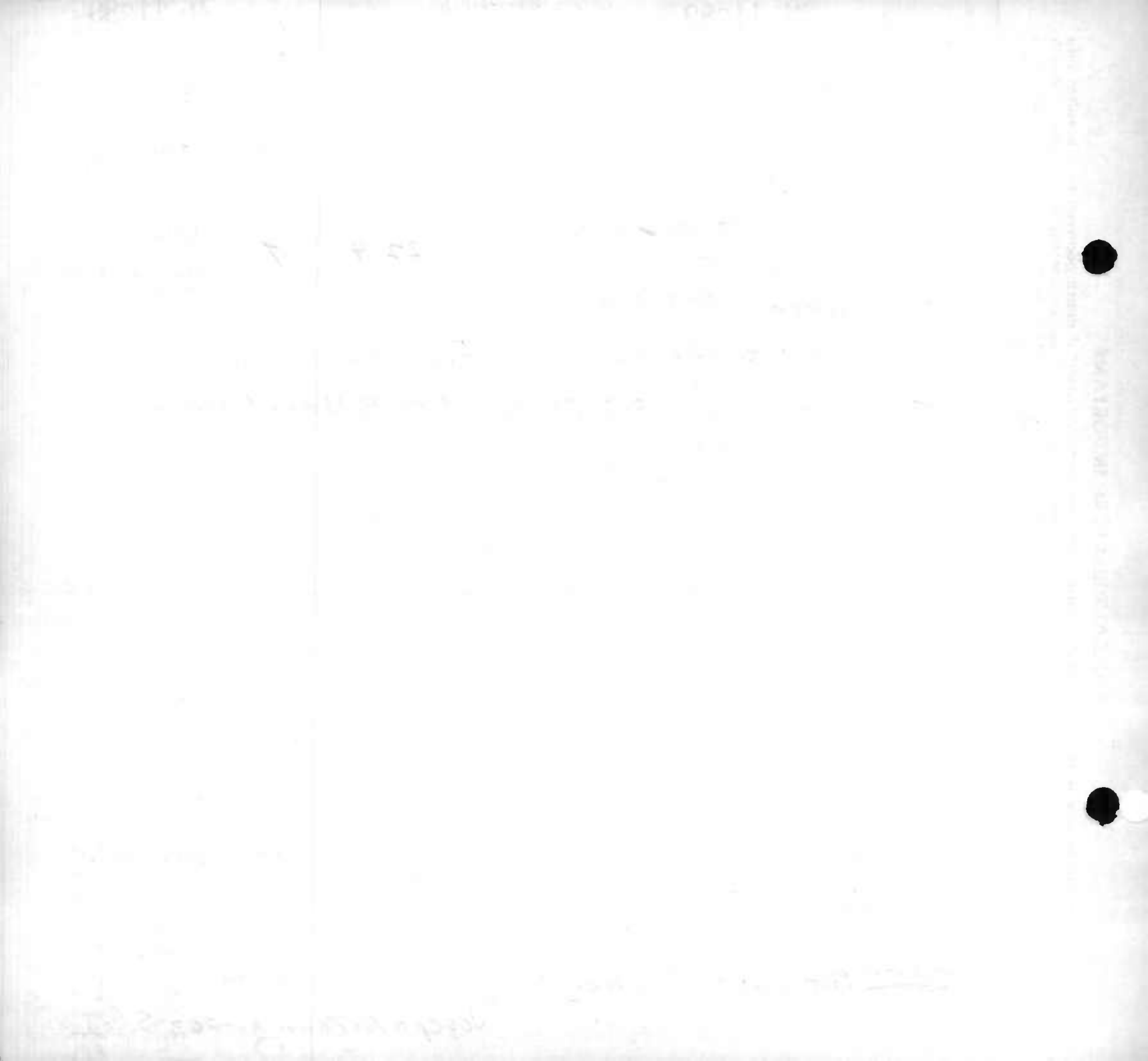
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">S-552</p> <p style="font-size: 24pt; margin: 0;">71 11388</p>		<p style="font-size: 12pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p>		<p style="font-size: 12pt; margin: 0;">REG. NO. 71 11388</p>	
<p>BIRTH NO. 3:05</p> <p>1. NAME OF DECEASED 265 P M.</p> <p style="font-size: 18pt;">SIMINSKI, ANTHONY J., JR.</p>			<p>2. DATE AND HOUR OF DEATH</p> <p style="font-size: 18pt;">12/5/71</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="font-size: 24pt;">23</p> <p style="font-size: 18pt;">Veterans Administration Hospital</p> <p style="font-size: 18pt;">3900 Loch Raven Boulevard</p> <p style="font-size: 18pt;">Baltimore, Maryland 21218</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY 2611</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 1106 S Highland Avenue</p>		
<p>5. SEX Male</p>	<p>6. RACE W</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 11/8/21</p>	<p>9. AGE (In years last birthday) 50</p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 18pt;">Guard</p>			<p>11. BIRTHPLACE (State or foreign country) Baltimore, Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>
<p>13. FATHER'S NAME Anthony Siminski</p>			<p>14. MOTHER'S MAIDEN NAME Gertrude Telleor</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>Yes 9/10/42 - 12/4/45</p>			<p>16. SOCIAL SECURITY NO. 215-16-71-52</p>		
<p>17. INFORMANT VA Hospital Records</p>			<p>ADDRESS 3900 Loch Raven Boulevard, Balto., Md 21218</p>		
<p>18. 592X I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p style="font-size: 18pt;">Acute myocardial infarction</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 hours</p> <p style="font-size: 18pt;">Pulmonary emboli</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: 2 hours</p> <p>(C) _____</p>			<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>		
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):</p>					
<p>19A. DATE OF OPERATION 11/28/71</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED left kidney</p>		<p>20A. AUTOPSY? (Yes or No) NO</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from October 15th 19 71 to December 5th 19 71, that (1) (we) last saw the deceased alive on December 5th 19 71 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.</p>					
<p>23A. SIGNATURE David S. McHold M.D.</p>				<p>23B. DATE SIGNED 12/6/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) DAVID S. McHOLD, M.D.</p>				<p>23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 12/9/71</p>		<p>24C. NAME OF CEMETERY or CREMATORY Oaklawn</p>	
<p>24D. LOCATION Baltimore, Maryland</p>		<p>24E. LOCATION (City, town, or county) (State)</p>			
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</p>		<p>25C. FUNERAL DIRECTOR Joseph N. Zannino - 263 S. Conkling Street</p>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-620 71 11389 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 11389 REG. NO.	
BIRTH NO. Surock 1. NAME OF DECEASED (Type or Print) Surock Thomas A.		2. DATE AND HOUR OF DEATH 12-8-71 3:20 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Ba B. COUNTY md C. CITY OR TOWN Ba D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1559 Worshire road 21218			
5. SEX m	6. RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-04	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) O H I O	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Lawrence Surock			
14. MOTHER'S MAIDEN NAME Frances Gull		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -			
16. SOCIAL SECURITY NO. 213-07-2889		17. INFORMANT Mrs. R. Patti - daughter ADDRESS			
18. 410.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute MI (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 8 19 71 to Dec 8 19 71 that (I) (we) last saw the deceased alive on Dec 8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Dec 8, 1971	
23C. PHYSICIAN'S NAME (Type) TULIO BENTORINI DEGREE		23D. ADDRESS UNION Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/71		24C. NAME OF CEMETERY OR CREMATORY Dalany Valley Mem.	
24D. LOCATION Ba 140. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph N. Zennino-263 S. Conkling St. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>520</u> <u>71 11390</u>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 11390</u>	
1. NAME OF DECEASED (Type or Print) <u>Young, Ruth WHITAKER</u>				2. DATE AND HOUR OF DEATH <u>12/8/71</u> <u>6:10 a.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>401</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>15 Charles Plaza Apt. 1606</u>			
5. SEX <u>Female</u>	6. RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/24/06</u>	9. AGE (in years last birthday) <u>65</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GAS & ELECTRIC CO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Whitaker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Twinong</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-2885</u>		17. INFORMANT <u>MARTIN A KIRCHER</u> ADDRESS <u>425 ST PAUL STREET</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration of gastric contents</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Malnutrition</u> <u>Carcinoma, (Radicular ridge, floor of mouth)</u> <u>Carcinoma of Esophagus</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>months.</u> <u>2 Yrs</u> <u>months</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Carcinoma of Esophagus</u>							
19A. DATE OF OPERATION <u>6 Dec 71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>DYSPHAGIA</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u></u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u></u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>70</u> to <u>8 Dec</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>7 Dec</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael E Jabaley, M.D.</u>				23B. DATE SIGNED <u>8 Dec 71</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael E. Jabaley, M. D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>DEC 11 1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>PROSPECT HILL CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>YORK RD TOWSON MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jabaley, M.D.</u>		25C. FUNERAL DIRECTOR <u>DIPPEL BROS INC</u> ADDRESS <u>1800 E LOMBARD ST</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11391	
BIRTH NO. 71 11391		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Luis RAMOS (or) LOUIS G. RAMOS		2. DATE AND HOUR OF DEATH December 7, 1971 4:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 203 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1710 Aliceanna Street #31			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/02	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SEAMAN		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) PUERTO RICO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNK			
14. MOTHER'S MAIDEN NAME UNK		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 083-14-1188		17. INFORMANT PEDRO P. SANTANA 413 S REISTER ST			
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the lung (B) Generalized bone metastasis DUE TO, OR AS A CONSEQUENCE OF: (C) -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 23 19 71 to December 7 19 71 that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Willard Appleford		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Willard Appleford	
23D. ADDRESS 6615 Westminster Rd		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE DEC 10 1971		24C. NAME OF CEMETERY OR CREMATORY ST STANISLAUS CFM		24D. LOCATION (City, town, or county) (State) DUNDALK AVE BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robt E. Fisher, M.D.		25C. FUNERAL DIRECTOR DIPPEL BROS INC 1800 E LOMBARD ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 71 11392		CERTIFICATE OF DEATH		REG. NO. 71 11392	
1. NAME OF DECEASED (Type or Print) JOSIE EDWARDS				2. DATE AND HOUR OF DEATH 12/7/71 2:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1002			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 835 ABBOTT COURT			
5. SEX FEMALE	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-99	9. AGE in years last birthday 72	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME LEE BROWN				14. MOTHER'S MAIDEN NAME MAMIE GATLING			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Thomas Edwards, Son		ADDRESS	
18. 519.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) RESTRICTIVE LUNG DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). MARKED HYPOSCOLIOSIS							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from 11/22/71 19 to 12/07/71 19 that (I) (we) last saw the deceased alive on 12/07/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ROBERT BUSTO	
				23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-13-71		24C. NAME of CEMETERY or CREMATORY Wheatley Cmt		24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR E. O. Wilson		ADDRESS	



1
S 323

71 11393

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11393

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Allen Stockett (Goulsen)

2. DATE OF DEATH
Known ☐ Month Day Year Hour
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

3. DATE PRONOUNCED DEAD Month Day Year Hour
December 7, 1971 6:30 p. M.

5. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)
A. STATE Maryland B. COUNTY 806

6. SEX
Male

7. RACE
Negro

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?
YES ☒ NO ☐

9. DATE OF BIRTH

March 12-1900

10. AGE (In years last birthday) 71
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1714 N. Washington Street

11. BIRTHPLACE (State or foreign country)

St. Mary & Md

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Louellen Stockett

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

15. MOTHER'S MAIDEN NAME

Mary Smith

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT ADDRESS
James Stockett 1112 Bonaparte St #2218

19. 412.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)
Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
12/8/71

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

(10-11-12)

The following is a list of the names of the persons who have been

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

BIRTH NO. 71 11394

1. NAME OF DECEASED
(Type or Print)

FRED JENKINS

2. DATE AND HOUR OF DEATH

12/6/71 8 55 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1923 E. Chase Street 21205

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

4-8-98

9. AGE (in years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Alonso

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

71

16. SOCIAL
SECURITY NO.

29-03-1853

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH RECORDS: Baltimore, Maryland 21224

18. 188X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

ACIDOSIS, HYPOTENSION

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH24 HOURS
? 4 HOURS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) ACUTE RENAL FAILURE, (GIBBERED) 2 DAYS
DUE TO, OR AS A CONSEQUENCE OF:

(C) METASTATIC CA OF BLADDER 4 YEARS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

S/P ILEAL LOOP.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the ~~hospital~~) attended the deceased from 4 PM 12/6 19 71 to 8 55 PM 12/6 19 71
that (I) ~~lost~~ lost saw the deceased alive on 12/6 19 71 and that in (my) ~~last~~ opinion death occurred on the date
and hour and from the causes stated above. (I) ~~was~~ (did) (did not) view the body after death.

23A. SIGNATURE

Joseph Roll M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/6/71

23C. PHYSICIAN'S
NAME (Type)

Joseph Roll, M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 9 1971

Robert E. Taber, M.D.

Clay Wilson, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

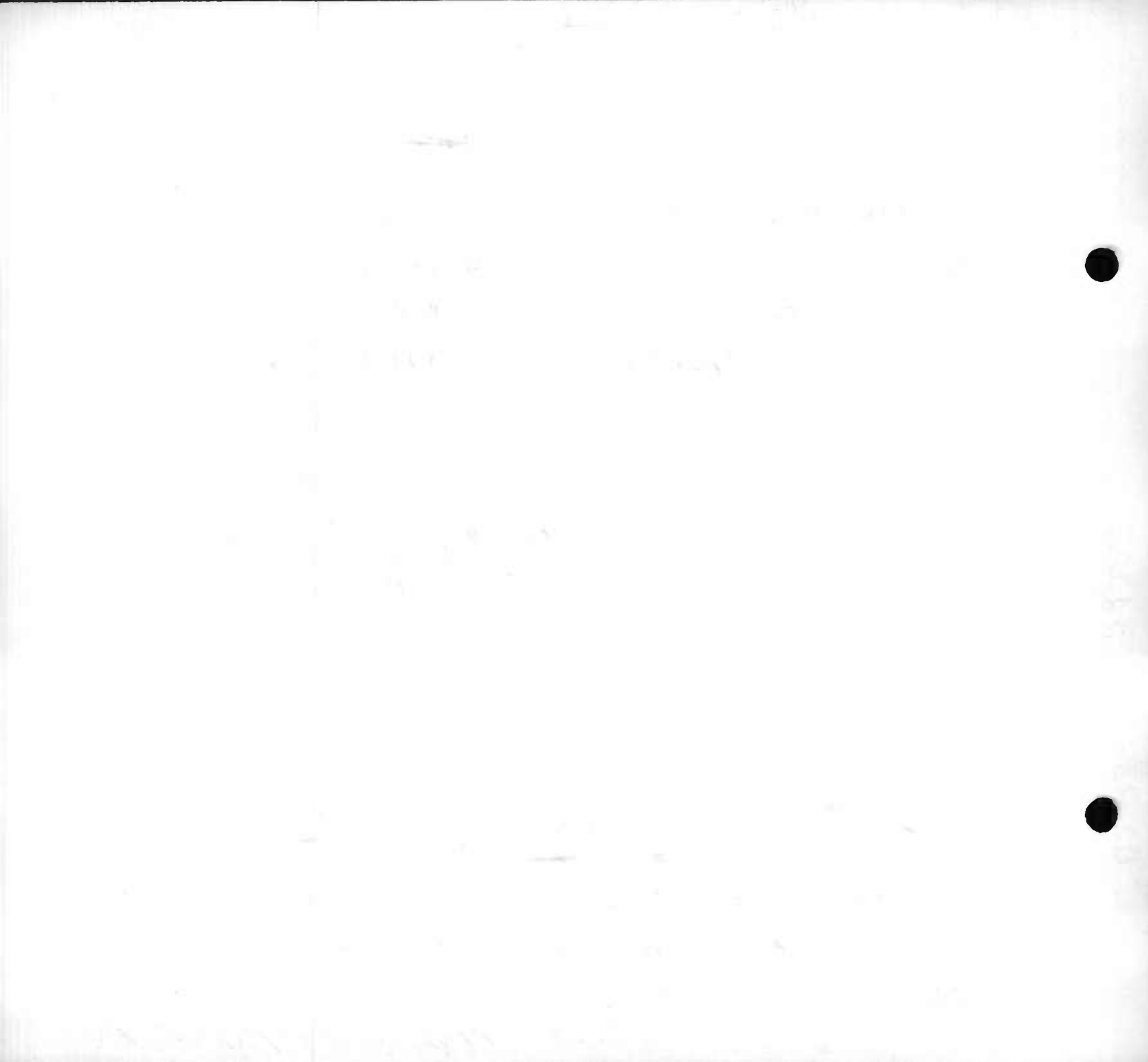
F 630 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 11395

BIRTH NO. 71 11395

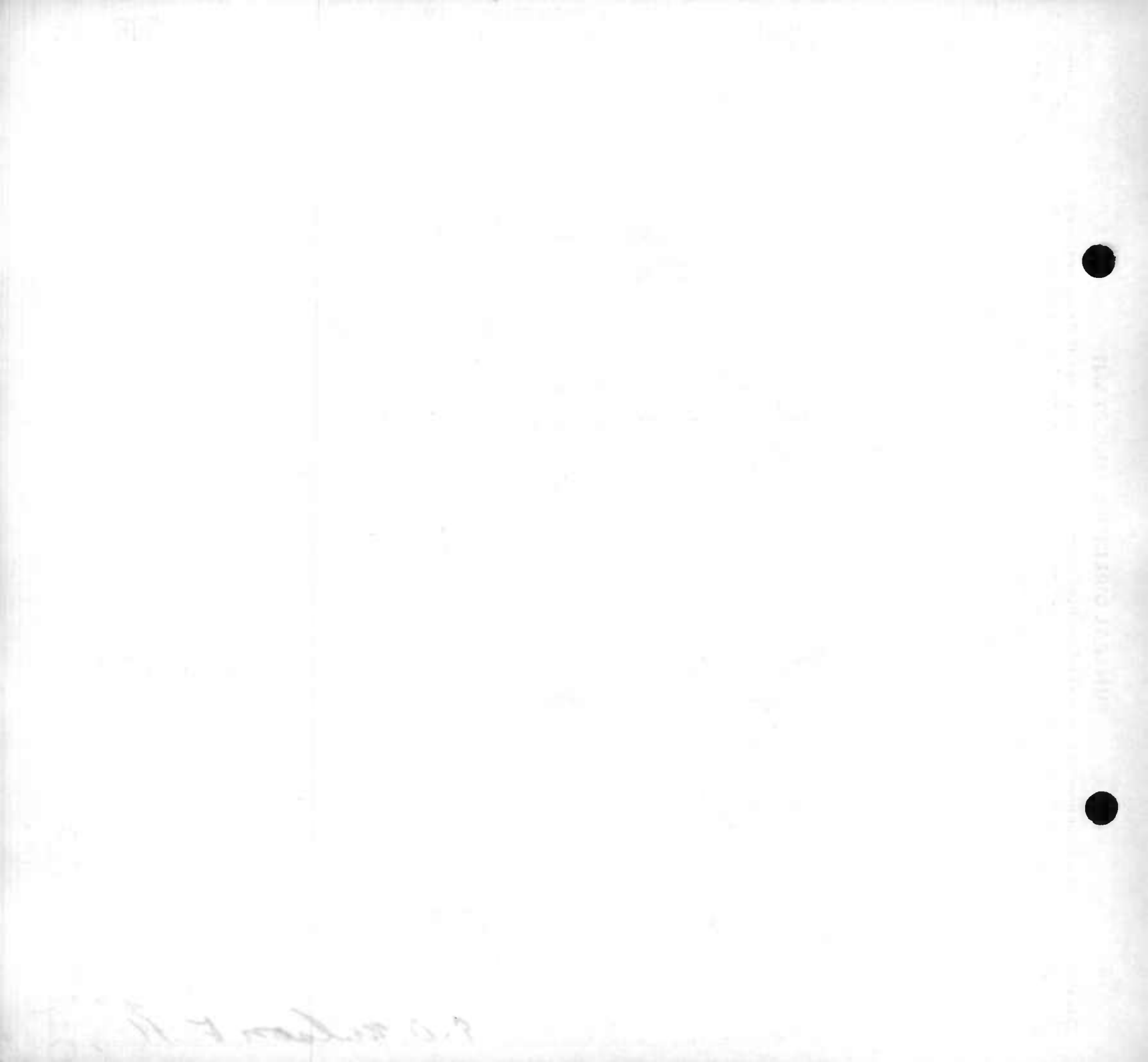
1. NAME OF DECEASED (Type or Print) MARY FORD		2. DATE AND HOUR OF DEATH 12/6/71 7:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 35 CHURCH HOME & HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1608	
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSPITAL		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 601 LINNARD ST.			
5. SEX Female	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME HARRISON RAYNER		14. MOTHER'S MAIDEN NAME EFFIE WALLACE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethel Yorker - Mother		ADDRESS	
18. 410.94 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Acute myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCD, Diabetes Mellitus (B) DUE TO, OR AS A CONSEQUENCE OF: & Complications (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH undetermined years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if) (this hospital) attended the deceased from 12-3 19 71 to 12/6 19 71 that (if) (we) last saw the deceased alive on 12/6 19 71 and that (if) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (not) view the body after death.			
23A. SIGNATURE W. M. MARIANO, M.D.		23B. DATE SIGNED 12/6/71	
23C. PHYSICIAN'S NAME (Type) WILMA B. MARIANO, M.D.		23D. ADDRESS CHURCH HOME & HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/71	
24C. NAME OF CEMETERY or CREMATORY Mount Vernon		24D. LOCATION (City, town, or county) (State) Ad Co County Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Talley, M.D.	
25C. FUNERAL DIRECTOR William 1000		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11396	
BIRTH NO. 71 11396		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DYKES, CORINE		2. DATE AND HOUR OF DEATH 12-6-71 7:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL 44		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1500 SHGFFIELD RD. 21218					
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-96	9. AGE (in years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN			
14. MOTHER'S MAIDEN NAME SOPHIE FIELDS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			
16. SOCIAL SECURITY NO.		17. INFORMANT George Dykes 5435 Spruce Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA + SEPSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRAL VASCULAR ACCIDENT.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD.			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-23 19 71 to 12-6 19 71 . that (I) (we) last saw the deceased alive on 12-6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julio A. Dejo				23B. DATE SIGNED 12-6-71	
23C. PHYSICIAN'S NAME (Type) JULIO A. DEJO M.D.				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-71		24C. NAME of CEMETERY or CREMATORY Northwood	
24D. LOCATION (City, town, or county) (State) Balto Md Md		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971			
25B. NAME OF REGISTRAR Robert E. Jarber, M.D.		25C. FUNERAL DIRECTOR S. O. Wilson F. H.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

14 200 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 11397

BIRTH NO. 71 11397

1. NAME OF DECEASED (Type or Print) Hicks, Nathaniel				2. DATE AND HOUR OF DEATH 12/7/71 12:37 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 806			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2036 E. Lanvale Street			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3/4/02	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Race Virginia	
13. FATHER'S NAME Henry Hicks				14. MOTHER'S MAIDEN NAME Ida Thornton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT John Hicks 2036 E. Lanvale St	
18. 2036 E. Lanvale St DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hemorrhage (B) Acute Myocardial Infarction & Cavitation (C) Chronic Monocytic Leukemia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes 1 month 5 months			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 10/4 19 71 to 12/7 19 71 that (1) (we) last saw the deceased alive on 12/7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jerome Kurent, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/7/71	
23C. PHYSICIAN'S NAME (Type) Jerome Kurent, M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-10-71		24C. NAME OF CEMETERY OR CREMATORY Mount Airy Cal		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Condon W. Brandy			



71 11398

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11398

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Beasley		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 3, 1971		3. DATE OF DEATH Month Day Year December 3, 1971	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital (DOA)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 301		6. SEX Male	
7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12-8-1898		10. AGE (In years last birthday) 73		E. STREET AND NUMBER 19 N. Eden Street	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT General B. Brown 313 Hunt St	
19. E 898 X		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Carbon monoxide intoxication			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 19 N. Eden Street 301	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12/3/71 AM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell against bed with cigarette	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 4, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE (State) Md			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS	
				Baltimore 10781 Mount Airy	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

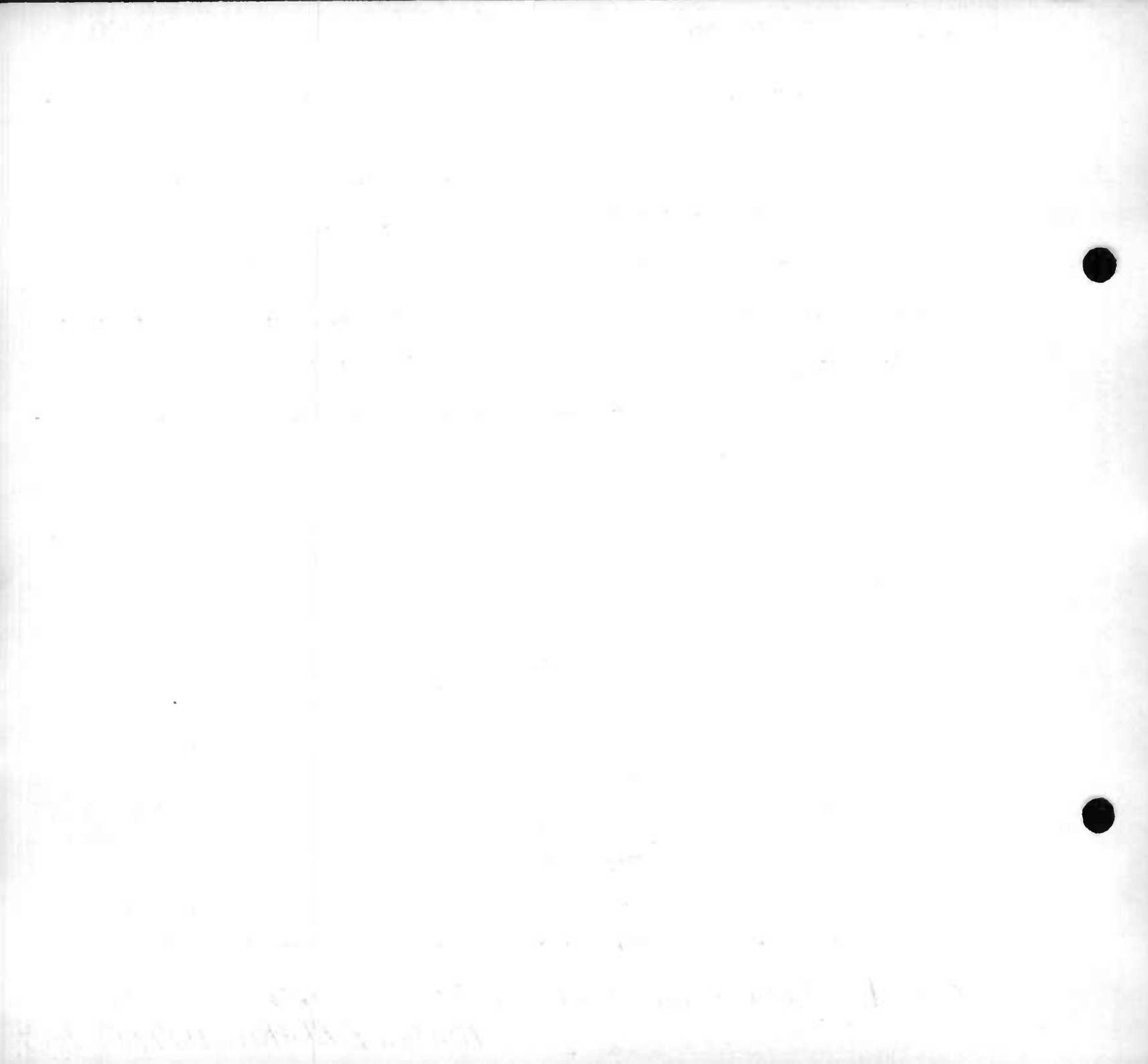
71 11399		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11399	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) PLATO JEAN		2. DATE AND HOUR OF DEATH 12/2/71 10:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO		C. CITY OR TOWN BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. OF BALTO		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 7/26/36		9. AGE (In years last birthday) 35		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Pitts	
14. MOTHER'S MAIDEN NAME Helen Sterling		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 183470	
17. INFORMANT Gloria Mitchner		ADDRESS		18. 430-91 CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SUB ARACHNOID HEMORRHAGE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/29 19 71 to 12/2 19 71 that (I) (we) last saw the deceased alive on 12/2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 12/2/71		23C. PHYSICIAN'S NAME (Type) DAVID GLASER, M.D.	
23D. ADDRESS SINAI HOSP. OF BALTO.		23E. FUNERAL DIRECTOR [Signature]		23F. ADDRESS [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-6-71		24C. NAME of CEMETERY or CREMATORY Crown Hill	
24D. LOCATION (City, town, or county) MD.		24E. STATE MD.		24F. COUNTY MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR [Signature]	
25D. ADDRESS [Signature]					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11400	
W-45271 11400				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary B. Williams		12/3/71 1:00 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1838 E. Madison Street		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Negro		12/6/97	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Laundress			Charles Co., Md.		U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John O. Young			Frances Fard		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			215-01-6953		Roosevelt Young, 2109 Ridgehill Ave.
18. 472.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			Atherosclerotic heart disease		unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF:		unknown
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>3 DEC 1971</u> to <u>3 DEC 1971</u> that (2) (we) last saw the deceased alive on <u>3 DEC 1971</u> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thomas A. Schnitzer</i>				23B. DATE SIGNED 12/3/71	
23C. PHYSICIAN'S NAME (Type) Thomas A. Schnitzer, M.D.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-9-71		New Cathedral Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 9 1971		Robert E. Taylor, Jr.		Milton E. Erickson 129 W. Grafton St.	



B-260

71 11401

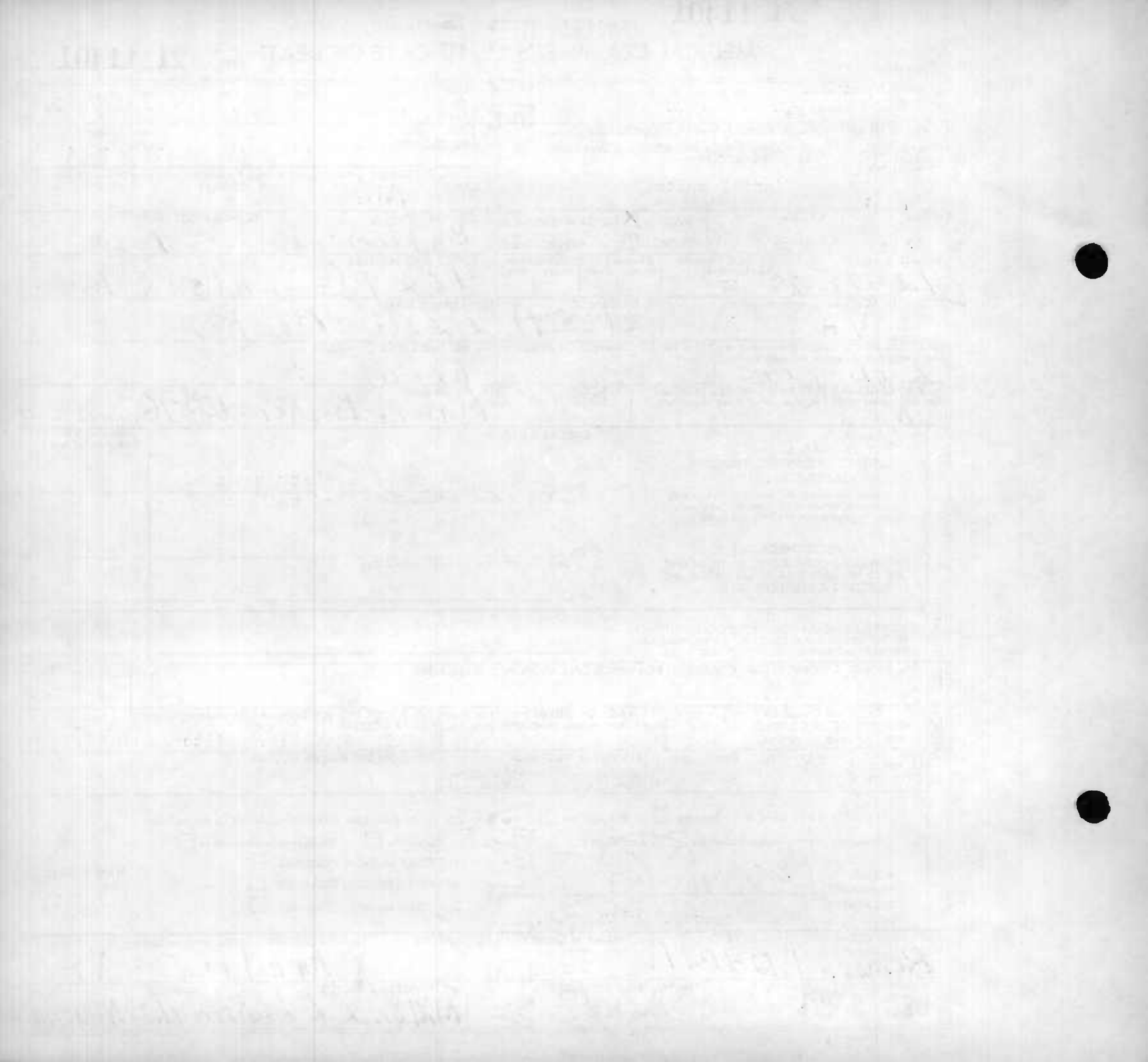
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11401

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Herman Booker				2. DATE OF DEATH Found <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 4 Year 71 Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital				3. DATE PRONOUNCED DEAD Month 12 Day 4 Year 71 Hour 7:15 P. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2798							
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12-25-23		10. AGE (In years last birthday) 47		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Ezzie Booker		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Nora		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT Marie Booker-4027 Garrison Ave.		19. CAUSE OF DEATH E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 12		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? Found: 4900 blk. Reisterstown Rd.		22D. TIME OF INJURY Found: Month 12 Day 4 Year 71	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found shot		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12-11-71		24C. NAME OF CEMETERY or CREMATORY Amenia, VA.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Werner U. Spitz, M.D.		25C. FUNERAL DIRECTOR Milton E. E. Lickson-1129 N. Cardine		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460 71 11402		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11402	
1. NAME OF DECEASED (Type or Print) <i>Elizabeth Taylor</i>		2. DATE AND HOUR OF DEATH <i>12/8/71 3 30 pm M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hospital of Md.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>908</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2326 Aiken St 21218</i>			
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-10-18</i>	9. AGE (In years last birthday) <i>53 yrs.</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Roger Hill</i>			
14. MOTHER'S MAIDEN NAME <i>Lucile (Jennett) Hill</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chae</i>			
18. <i>616.01</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Septicemia</i> <i>Ruptured</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>pelvic Abscess</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>> 12 hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) I (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/7/71</i> 19 to <i>12/8/71</i> 19 that (I) (we) last saw the deceased alive on <i>12/7/71</i> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>D. S. Karbhari</i>		23B. DATE SIGNED <i>12/8/71</i>		23C. PHYSICIAN'S NAME (Type) <i>Dilip S. Karbhari</i>	
23D. ADDRESS <i>Lutheran Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>12/11/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Westport Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 9 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Michael E. Ellick</i>	



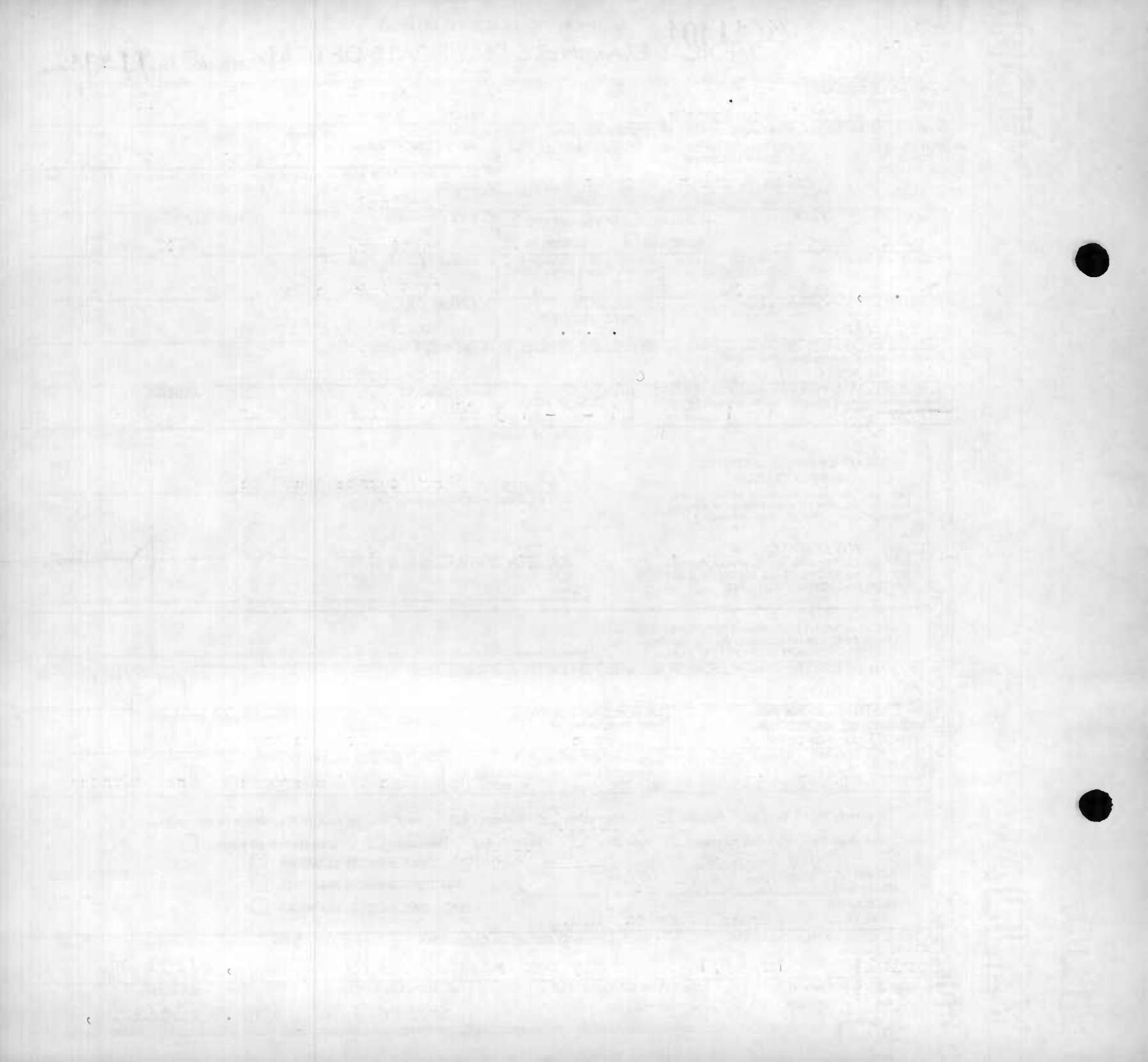
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11403	
D-263 71 11403		CERTIFICATE OF DEATH	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) John C. DECKERT		12-8 171 1P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		A. STATE MARYLAND B. COUNTY 903	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 800 VENABLE AVENUE 21218	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-03-1900
		9. AGE (In years last birthday) 71	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ENGINEER STATE OF MD.		11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN C. DECKERT, SR.		14. MOTHER'S MAIDEN NAME ELIZABETH EISENHARDT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-07-7805A	
		17. INFORMANT ADDRESS MRS. JOHN C. DECKERT (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 153.8 I		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolus seconds	
		(B) Terminal carcinoma of colon metastasis 3 weeks DUE TO, OR AS A CONSEQUENCE OF:	
		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 11-26-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-1 19 71 to 12-8 19 71 and that (I) (we) last saw the deceased alive on 12-8 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Allen S. Glushatan		23B. DATE SIGNED 12-8-71	
23C. PHYSICIAN'S NAME (Type) Dr. Allen S. Glushatan		23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-71	
24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	



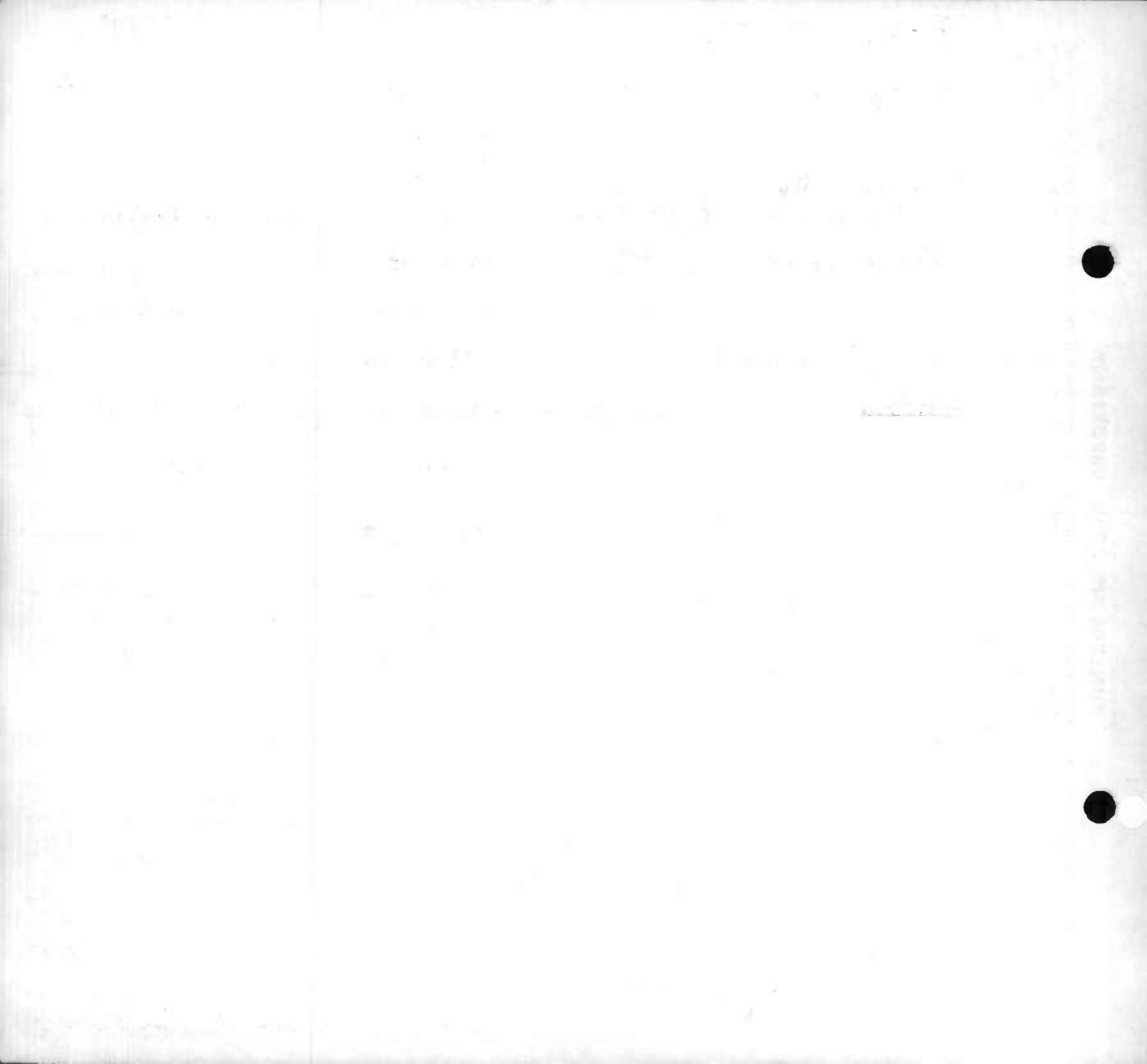
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 11404	
1. NAME OF DECEASED (Type or Print) J. <u>Alphonse Harris</u>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 7 71 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 7 71 2:30 A.M.			
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2741</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <u>Male</u>		7. RACE <u>White</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		E. STREET AND NUMBER <u>5115 Ardmore Way</u>	
9. DATE OF BIRTH <u>Dec 26 1938</u>		10. AGE (in years last birthday) <u>32</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vending Machine Mechanic</u>				15. MOTHER'S MAIDEN NAME <u>Rose Barauskas</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 1956 to 1960</u>				17. SOCIAL SECURITY NO. <u>216-36-3173</u>		18. INFORMANT ADDRESS <u>Mr William C Harris Same</u>	
19. <u>E 950.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Barbiturate overdose</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <u>No</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <u>5115 Ardmore Way 2741</u>			
22D. TIME OF INJURY (APPROX.) <u>12-6/7 71</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Ingested overdose of barbiturates</u>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-7-71</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/9/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DEC'D BY HEALTH DEPT. <u>DEC 9 1971</u>		25B. NAME OF REGISTRAR <u>Leonard J Ruck Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Baltimore, Md</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

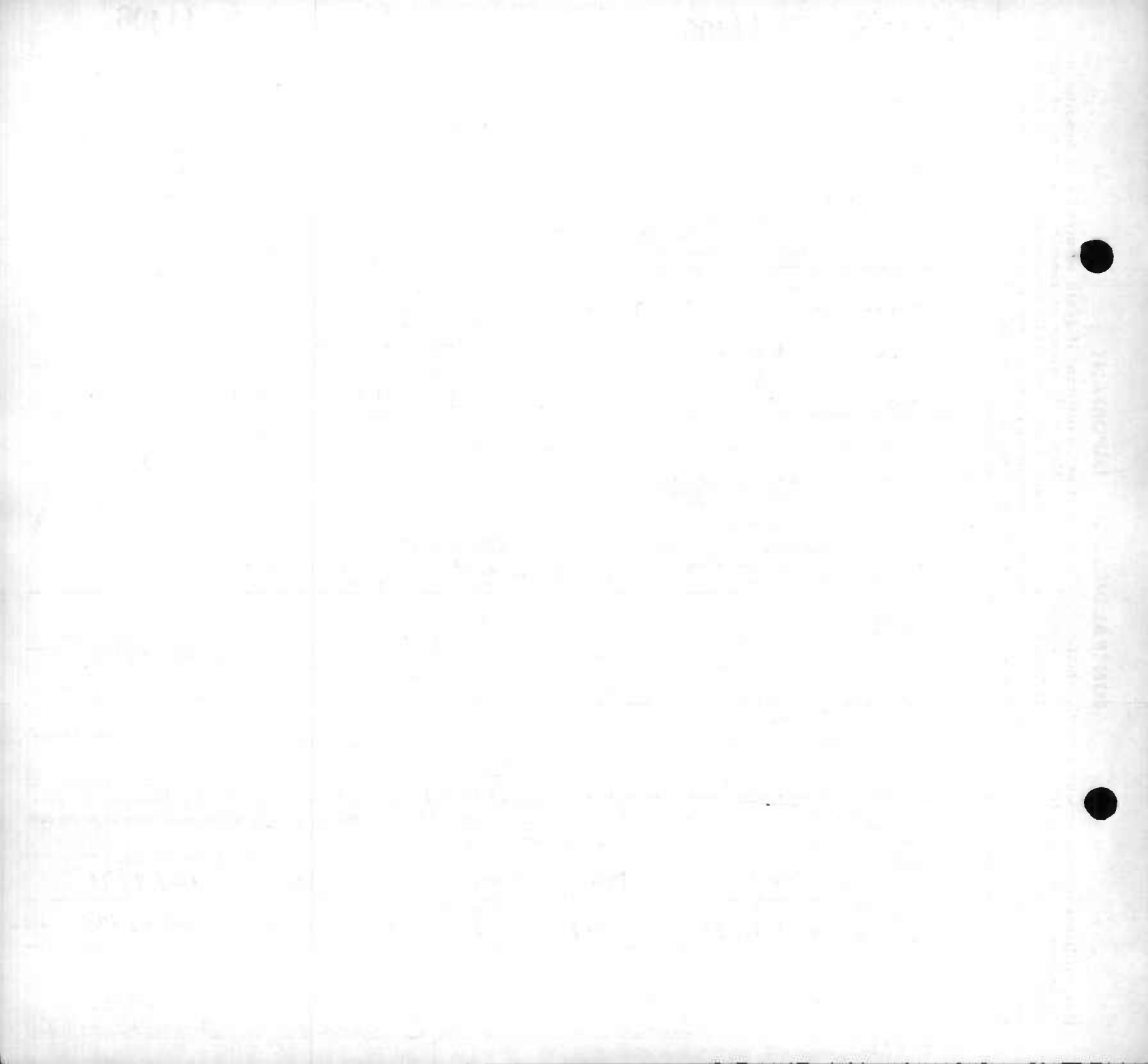
B-261 71 11405		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11405	
1. NAME OF DECEASED (Type or Print) Margaret C Beecraft				2. DATE AND HOUR OF DEATH Dec 7, 1971 3 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto			
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 33rd Calvert St. Balto MD 21218		C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 20 1888	
9. AGE (in years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A		13. FATHER'S NAME John Z Beall		14. MOTHER'S MAIDEN NAME Marcellean Beall		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218521166		17. INFORMANT Mrs. Laura Ragland		ADDRESS 2819 The Alameda		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.9 I				(A) IMMEDIATE CAUSE CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) SEPSIS DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic brain syndrome Diabetes				(C) _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (if in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/3 19 71 to 12/7 19 71 that (I) (we) last saw the deceased alive on 12/7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ramon De Busto MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/7/71	
23C. PHYSICIAN'S NAME (Type) Ramon De Busto MD		23D. ADDRESS UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/10/71		24C. NAME of CEMETERY or CREMATORY Lakeview Cemetery		24D. LOCATION (City, town, or county) (State) Carroll Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR John E. Talley, M.D.		25C. FUNERAL DIRECTOR LEONARD J. RUCK INC		ADDRESS BALTO 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">Baltimore City Health Department</h2> <h1 style="margin: 0;">CERTIFICATE OF DEATH</h1>		REG. NO. 71 11406	
V-452 71 11406 BIRTH NO.			
1. NAME OF DECEASED (Type or Print) VALUNAS HELEN W.		2. DATE AND HOUR OF DEATH 12/7/71 545 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South BALTIMORE GENERAL Hospital		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MD B. COUNTY 2404 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1703 Conington st	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 1, 1912 9. AGE (In years last birthday) 59 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John SOKOLOSKI		14. MOTHER'S MAIDEN NAME STELLA NEBZADOWSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 203-01-3908	
17. INFORMANT J. V. MAGRI, M.D.		ADDRESS 3001 S. HANOVER ST. - 21230	
18. 250.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Left Side Atherosclerotic accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis		(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pneumonia.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/6/71 19 71 to 12/7/71 19 71 that (I) (we) last saw the deceased alive on 7/12 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. MY (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature] M.D.		23B. DATE SIGNED 12/7/71	
23C. PHYSICIAN'S NAME (Type) Julio V. MAGRI M.D.		23D. ADDRESS 3001 S. HANOVER ST. BALTO, MD 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-11-71	
24C. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK		24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR [Signature]		ADDRESS 130 E. AR. AVE BALTO. MD. 21230	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

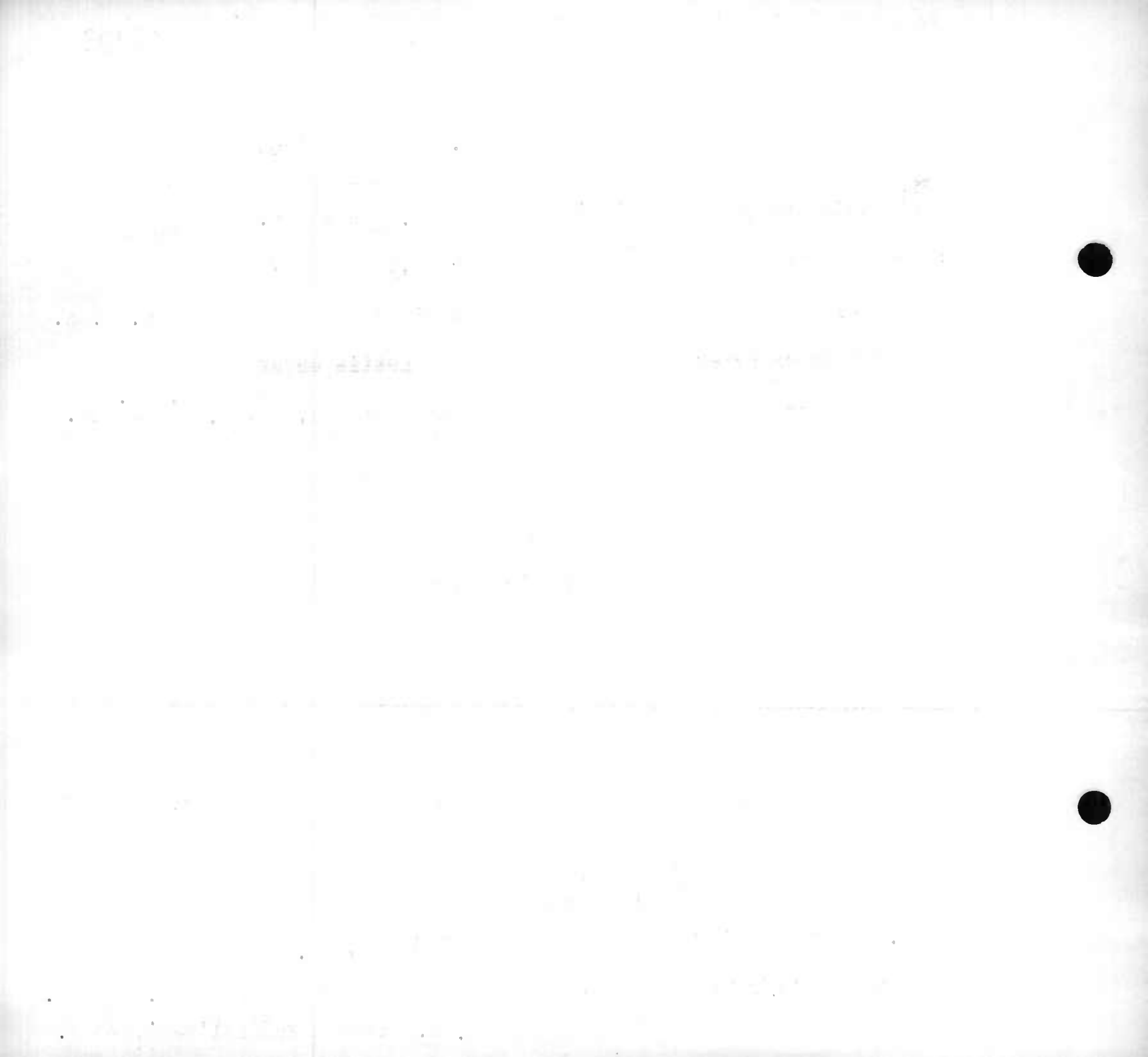
<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		REG. NO. 71 11407	
C-615 71 11407 BIRTH NO.		1. NAME OF DECEASED (Type or Print) CORBIN Mildred	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore, Inc Belvedere Avenue at Greenspring Baltimore, Md. 21215		2. DATE AND HOUR OF DEATH 12-6-1971 5:00 A.M.	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY BALTO		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. STREET AND NUMBER 58 Orville Rd. md 21221		7. SEX Female 8. RACE White	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. DATE OF BIRTH 12-10-1901 11. AGE (in years last birthday) 69	
12. BIRTHPLACE (State or foreign country) MARYLAND		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Louis Scribner		15. MOTHER'S MAIDEN NAME Leveria Paynter	
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 220-18-8794	
18. INFORMANT LORETTA Blaney ADDRESS Same		19. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 199.01 Carcinomatosis (Primary site of Carcinoma unknown)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last). II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
20. DATE OF OPERATION 12-22-1971		21. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
24. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		25. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
26. HOW DID INJURY OCCUR?		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. I certify that (this hospital) attended the deceased from 11-22-1971 to 12-6-1971 that (we) last saw the deceased alive on 12-5-1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
29. SIGNATURE D. Patel M.D.		30. DATE SIGNED 12-6-71	
31. PHYSICIAN'S NAME (Type) Khushal D. Patel, M.D., F.R.C.S.		32. ADDRESS Sinai Hospital of Baltimore, Inc.	
33. BURIAL CREMATION, REMOVAL (Specify) BURIAL		34. DATE 12-9-71	
35. NAME OF CEMETERY OR CREMATORY Moreland Memorial		36. LOCATION (City, town, or county) (State) Baltimore Md	
37. DATE REC'D BY HEALTH DEPT. DEC 9 1971		38. NAME OF REGISTRAR Robert E. Fisher, M.D.	
39. FUNERAL DIRECTOR CHAS. F. EVANS & Son		40. ADDRESS 8802 Hartford Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

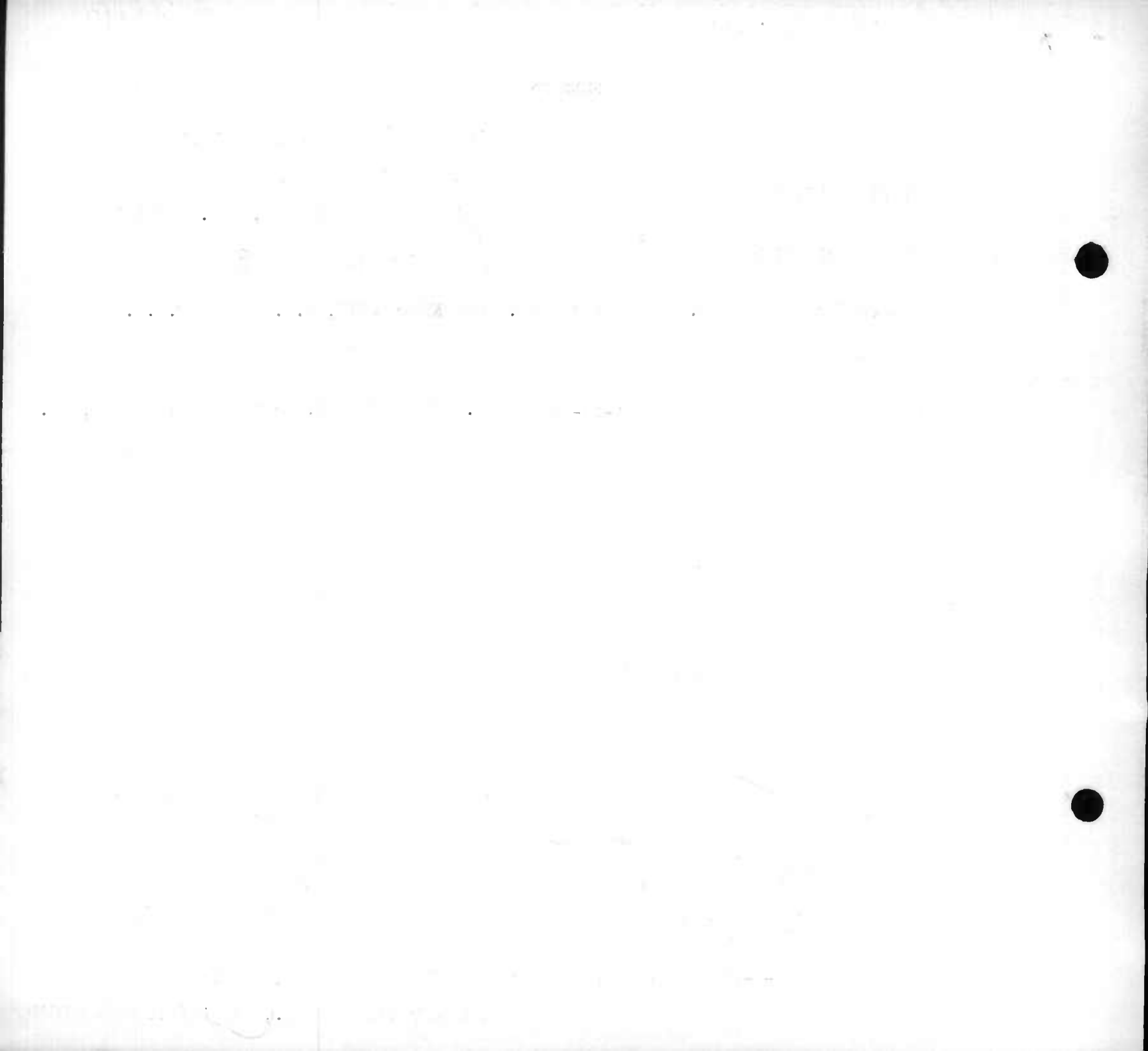
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 11408</u>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>KATHLEEN HOLMES</u>				2. DATE AND HOUR OF DEATH <u>12/6/71</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Maryland Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Washington</u> C. CITY OR TOWN <u>Hagerstown</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>237 S. Locust St.</u>			
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1924</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		9. AGE (In years last birthday) <u>47</u> If Under 1 Yr. Months Days If Under 24 Hrs. Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Jacob Oscar Baker</u>			
14. MOTHER'S MAIDEN NAME <u>Lottie Guyer</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Hagerstown, Md.</u> <u>Chester Holmes, 237 S. Locust St.</u>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Anoxic Anemia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Upper GI Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>A-V malformation of stomach.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>(* Jehovah's Witness - refused further)</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-19</u> <u>1971</u> to <u>12-6</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>12-6</u> <u>1971</u> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Gerard Crowley M.D.</u>				23B. DATE SIGNED <u>12-6-71</u>		23C. PHYSICIAN'S NAME (Type) <u>J. Gerard Crowley</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12/9/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Cedar Lawn Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Hagerstown, Wash. Md.</u>				25A. NAME REC'D BY HEALTH DEPT. <u>DEC 9 1971</u>			
25B. NAME OF REGISTRAR <u>E. S. S. S.</u>				25C. FUNERAL DIRECTOR <u>Hagerstown, Md.</u> <u>A. K. Coffman Funeral Home, 40 E.</u>			



BIRTH NO.		71 11409		BALTIMORE CITY HEALTH DEPARTMENT		71 11409	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. NAME OF DECEASED (Type or Print) DAVID L. OWENS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 5 1971 12:55p.m.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore				C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 419 Willow Avenue. 5300	
9. DATE OF BIRTH 1-27-50		10. AGE (in years lost birthday) 21		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				15. MOTHER'S MAIDEN NAME Muriel I. Gregory			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. ?		18. INFORMANT Mother: 419 Willow Avenue Balto. Md. 21219	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 92219 (A) IMMEDIATE CAUSE Gunshot wound of abdomen DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Box 333 Poplar Ave. 5300		22F. HOW DID INJURY OCCUR? Gun accidentally discharged striking subject	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12-5-71		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-71		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

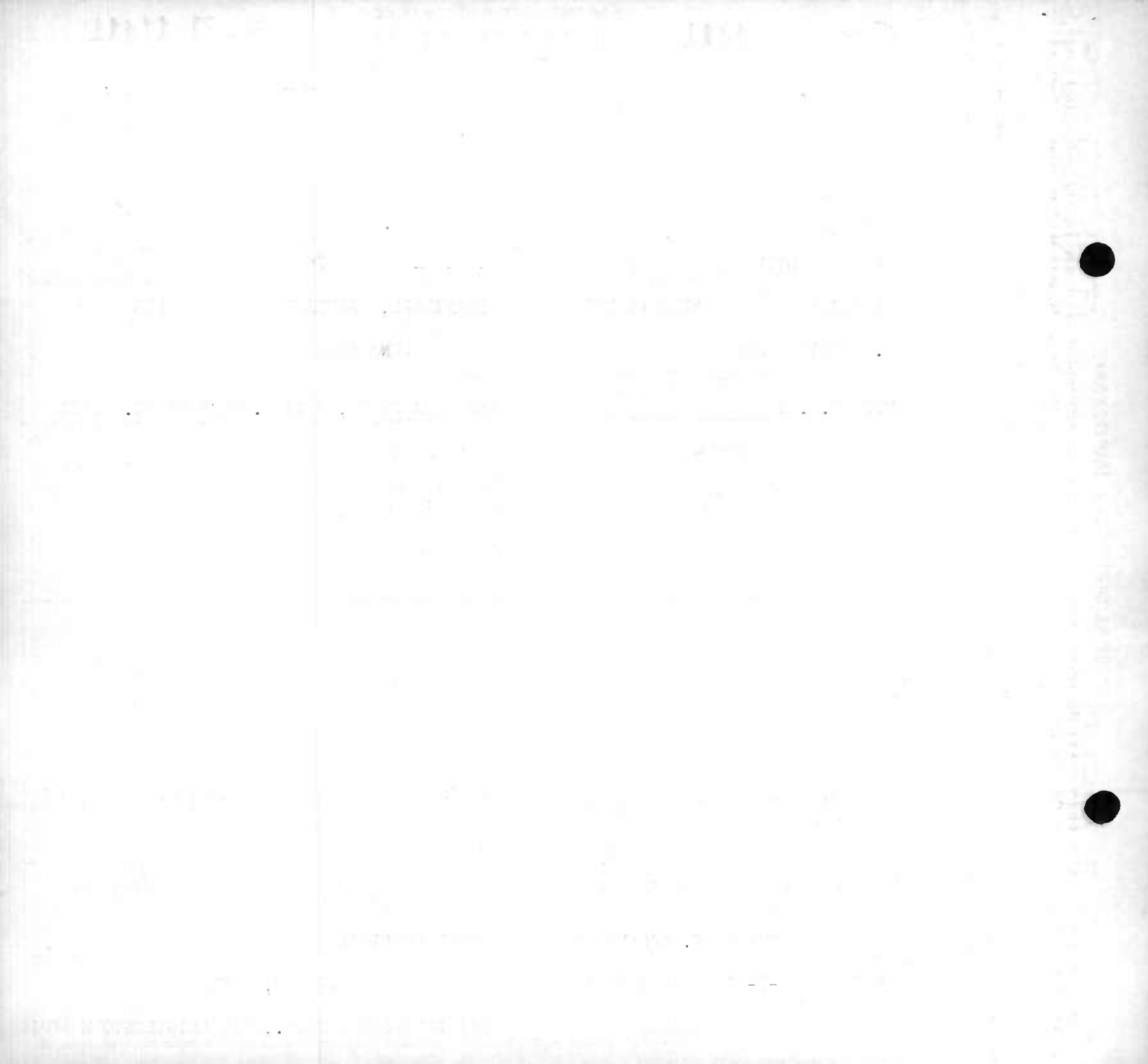
BALTIMORE CITY HEALTH DEPARTMENT		71 11410		REG. NO. 71 11410	
J-212 71 11410					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) JACOBS, Solomon			2. DATE AND HOUR OF DEATH 12-5-71 9-50 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4007 FORDLEIGH ROAD, APT. C #21215		
5. SEX Male	6. RACE XX WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-1893	9. AGE (in years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE		10B. KIND OF BUSINESS OR INDUSTRY MD. SHIPBUILDING CO.		11. BIRTHPLACE (State or foreign country) NEW YORK CITY, N.Y.	
13. FATHER'S NAME UNKNOWN			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 218-10-2341		17. INFORMANT MRS. SOPHIE JACOBS, 4007 FORDLEIGH ROAD, APT. C
18. CAUSE OF DEATH 4-12-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Arteriosclerosis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Gangrenous Appendicitis					
19A. DATE OF OPERATION 12-4-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Appendicitis		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-13-1971 to 12-5-1971 that (I) (we) last saw the deceased alive on 12-5-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. Patel			23B. DATE SIGNED 12-5-1971		23C. PHYSICIAN'S NAME (Type) Khushal D. Patel, M.D., F.R.C.S.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 12-7-71		24C. NAME of CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971			25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD
24D. LOCATION (City, town, or county) (State) BALTIMORE, Maryland			25D. ADDRESS ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

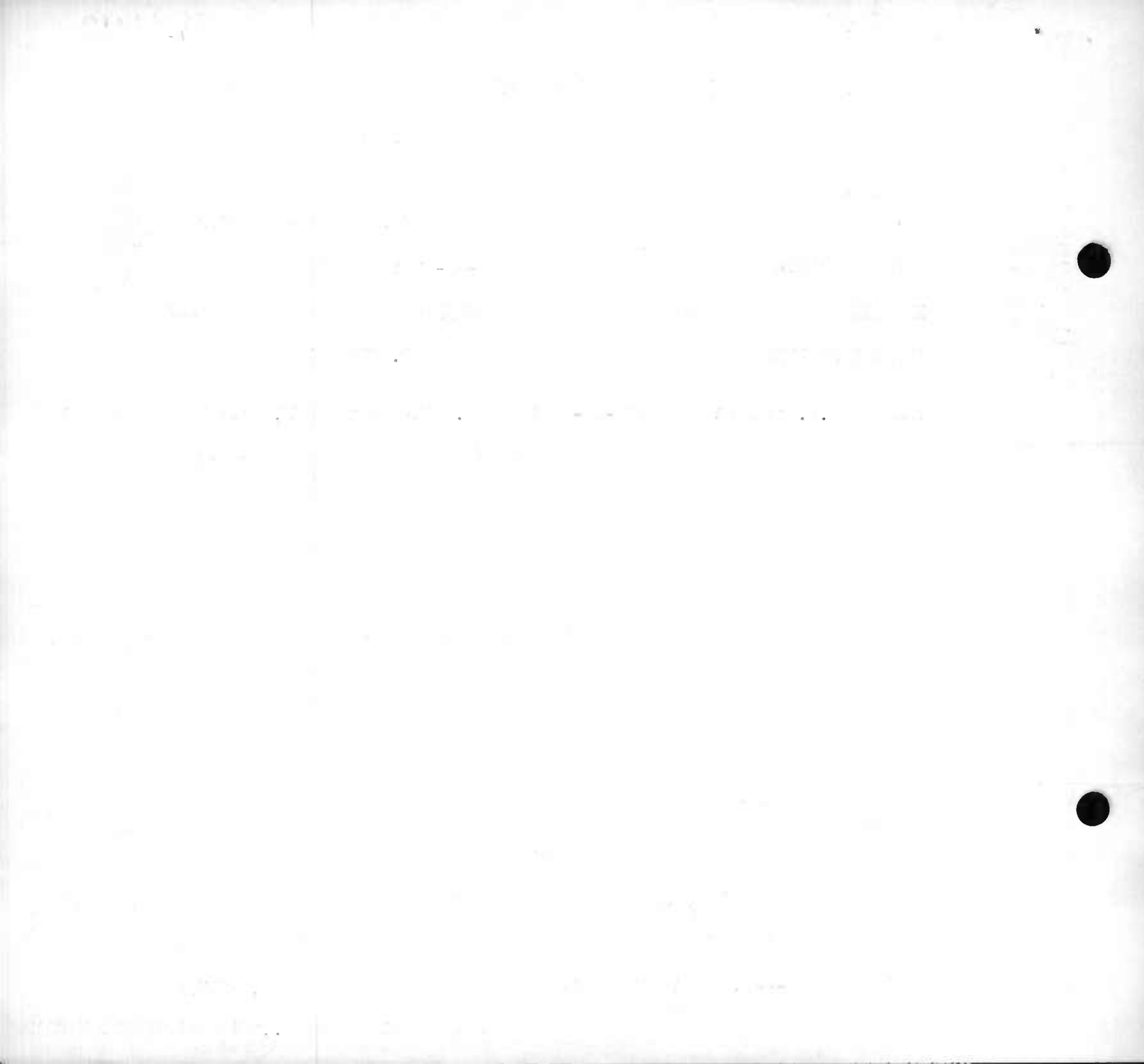
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11411</u>	
C-500 71 11411		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Cohen, Charles</u>		2. DATE AND HOUR OF DEATH <u>12-6-71</u> <u>8:22 AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>401</u>		C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>12-23-91</u>		9. AGE (in years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>H. MORRIS COHEN</u>	
14. MOTHER'S MAIDEN NAME <u>LENA KAHN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES W.W. I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MISS DENA COHEN, 4514 N. CHARLES ST. #21210</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: <u>interatrial extension</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>12/7/71</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>above</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>12/2</u> 19 <u>71</u> to <u>12/6</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>12/5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles J. Lancelata</u>		23B. DATE SIGNED <u>12/6/71</u>		23C. PHYSICIAN'S NAME (Type) <u>CHARLES J. LANCELATA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-7-71</u>		24C. NAME of CEMETERY or CREMATORY <u>BNAI ISRAEL</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		25D. ADDRESS		25E. FUNERAL DIRECTOR	



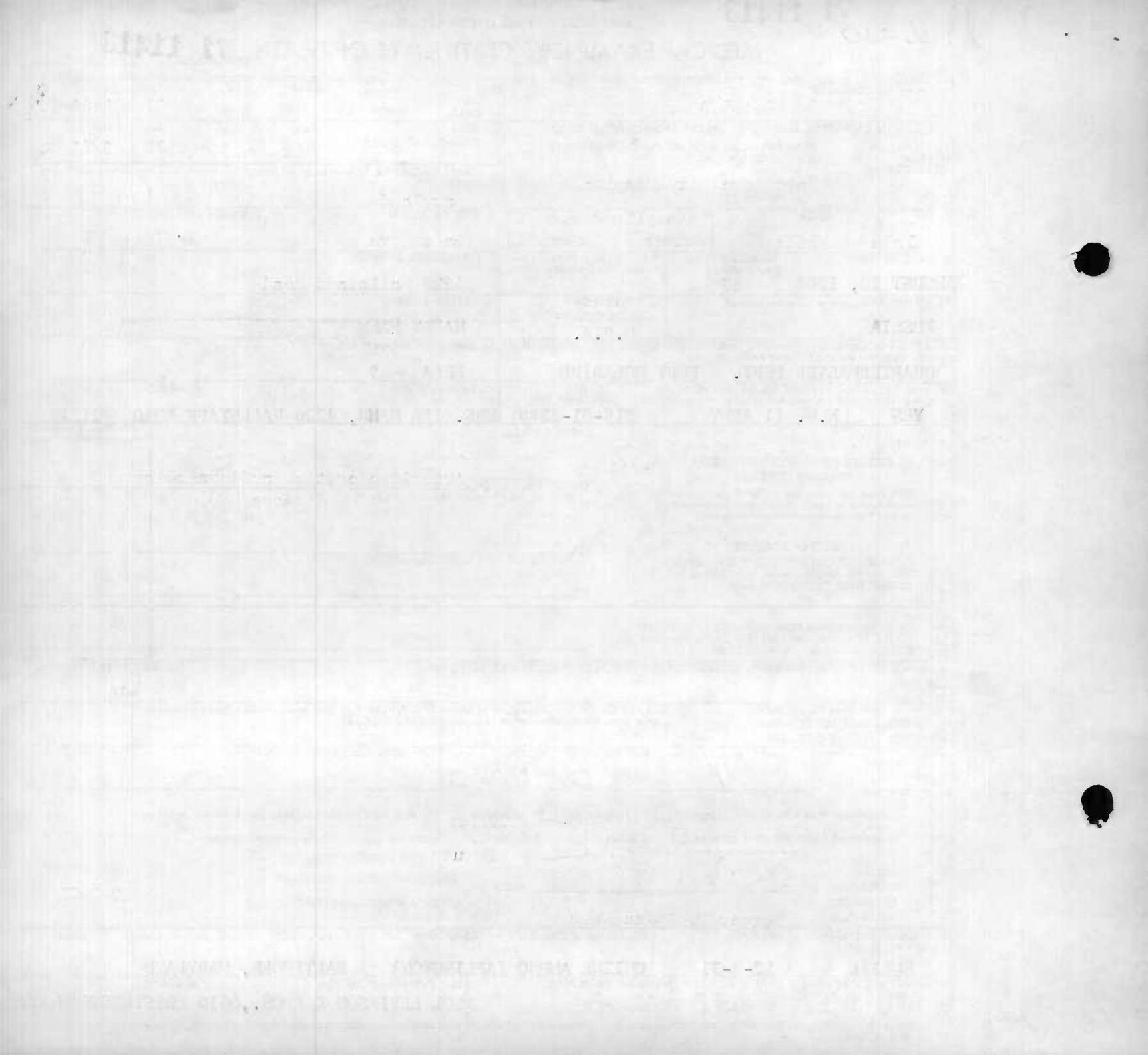
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11412	
BIRTH NO. S-515		71 11412		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JACOB. SCHONEBAUM.			2. DATE AND HOUR OF DEATH Dec 5, 1971 7:55 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL			A. STATE MARYLAND B. COUNTY BALTO		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 6054 FALLS ROAD #21209					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-1911	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL		10B. KIND OF BUSINESS OR INDUSTRY GROCER		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME ISAAC SCHONEBAUM			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY			16. SOCIAL SECURITY NO. 212-14-1301		17. INFORMANT MRS. RUTH SCHONEBAUM, 6054 FALLS ROAD #21209
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertension			CAUSE OF DEATH ACUTE Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MINS
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan - 1965 to Dec 5 1971 that (I) (we) last saw the deceased alive on Sept. 20 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gilbert J. Himelfarb			23B. DATE SIGNED Dec 5, 1971		
23C. PHYSICIAN'S NAME (Type) ALBERT J. HIMELFARB			23D. ADDRESS 222 W. Cold Spring Ave BALTO 21210		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-6-71		24C. NAME OF CEMETERY OR CREMATORY RODFE ZEDEK	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971			
25B. NAME OF REGISTRAR Robert L. Smith, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



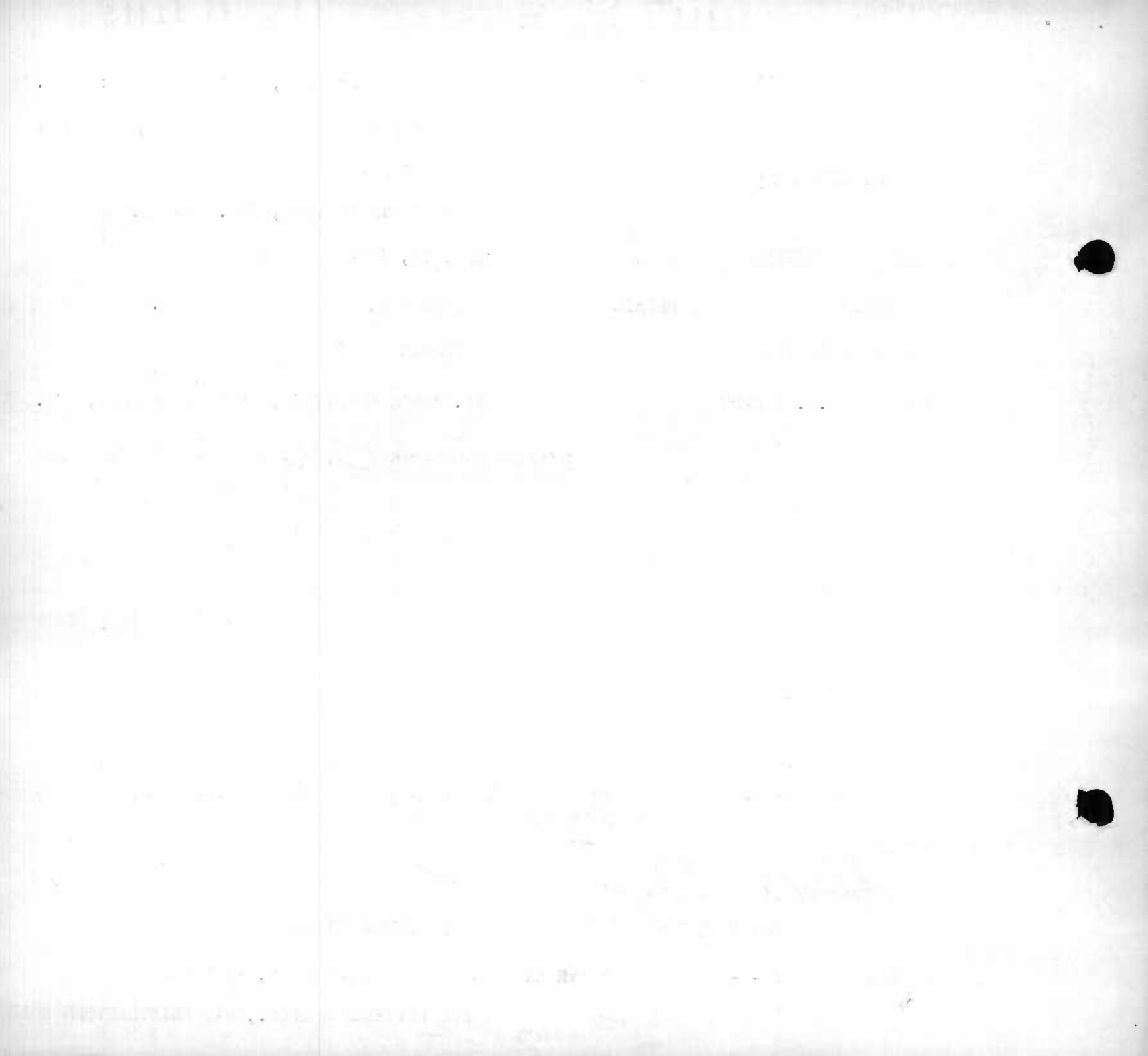
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
Max Hahn		Known <input checked="" type="checkbox"/> Month 12 Day 6 Year 71 Hour 3:47 P.M.		Month 12 Day 6 Year 71 Hour 3:47 P.M.		Baltimore City Hospital		Maryland B. COUNTY 2831	
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH AUGUST 10, 1904		10. AGE (In years lost birthday) 67		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY HAHN	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) QUARTERMASTER DEPT.		14b. KIND OF BUSINESS OR INDUSTRY FORT HOLABIRD		15. MOTHER'S MAIDEN NAME ZERA ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) MES W.W. II ARMY		17. SOCIAL SECURITY NO. 215-01-2589	
18. INFORMANT MRS. IDA HAHN		ADDRESS 4226 FALLSTAFF ROAD		21. AUTOPSY? (Yes or No) Yes		22. DATE OF OPERATION 2		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)		24B. DATE 12-8-71		24C. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-8-71		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. DEC 9 1971	
24F. NAME OF REGISTRAR Robert E. Farber, M.D.		24G. FUNERAL DIRECTOR SOL LEVINSON & BROS.		24H. ADDRESS 6010 REISTERSTOWN ROAD		24I. DATE SIGNED 12-7-71		24J. NAME OF CEMETERY or CREMATORY BALTIMORE, MARYLAND	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11414	
G-432 71 11414				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) DAVID GOLDSTEIN				DECEMBER 5, 1971 4:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL 42				A. STATE MARYLAND B. COUNTY 2720	
				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3601 CLARKS LANE, APT. 505 #21215	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 21, 1896	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME NATHAN GOLDSTEIN				12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I ARMY				16. SOCIAL SECURITY NO.	
				17. INFORMANT ADDRESS MRS. ADELE GOLDSTEIN, 3601 CLARKS LANE, APT. 505	
18. 41221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 9 yrs (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 29 1970 to Nov 29 1971 , that (I) (we) last saw the deceased alive on Nov 29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald H. Dembo MD DEGREE				23B. DATE SIGNED Dec 6, 1971	
23C. PHYSICIAN'S NAME (Type) DONALD DEMBO DEGREE				23D. ADDRESS 827 LINDEN AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-7-71		24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



BALTIMORE CITY HEALTH DEPARTMENT				71 11415			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				71 11415			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) ESTHER GIURLANI GIURLANI				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour 11 29 1971 1:30 a M.			
6. SEX female				7. RACE white			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				C. CITY OR TOWN Balto.			
9. DATE OF BIRTH JULY 15, 1904				10. AGE (in years last birthday) 67			
11. BIRTHPLACE (State or foreign country) MISSOURI				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR				14B. KIND OF BUSINESS OR INDUSTRY RESTAURANT			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				17. SOCIAL SECURITY NO. 561-22-9866			
18. INFORMANT HEBREW FREE BURIAL SOCIETY, C/O MR. MOSE MORRIS				ADDRESS 3737 CLARKS LANE, APT. 101 #21215			
19. E930.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH Hypotensive Shock and Cardiac Arrest complicating General Anesthesia for abdominal surgery (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 11-28-71				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Obstruction			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital			
22D. TIME OF INJURY (APPROX.) 11-28-71 9:00				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Therapeutic Misadventure				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Sinai Hospital 22-17			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				21. AUTOPSY? (Yes or No) yes			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 11-29-71							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 12-7-71			
24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971				25B. NAME OF REGISTRAR R. E. Taylor, M.D.			
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				ADDRESS			

Letter from M.E.'s office 12-21-71 M.H.

*12/27/71 - Operation 11/28/71 - Information
via phone med exam office*

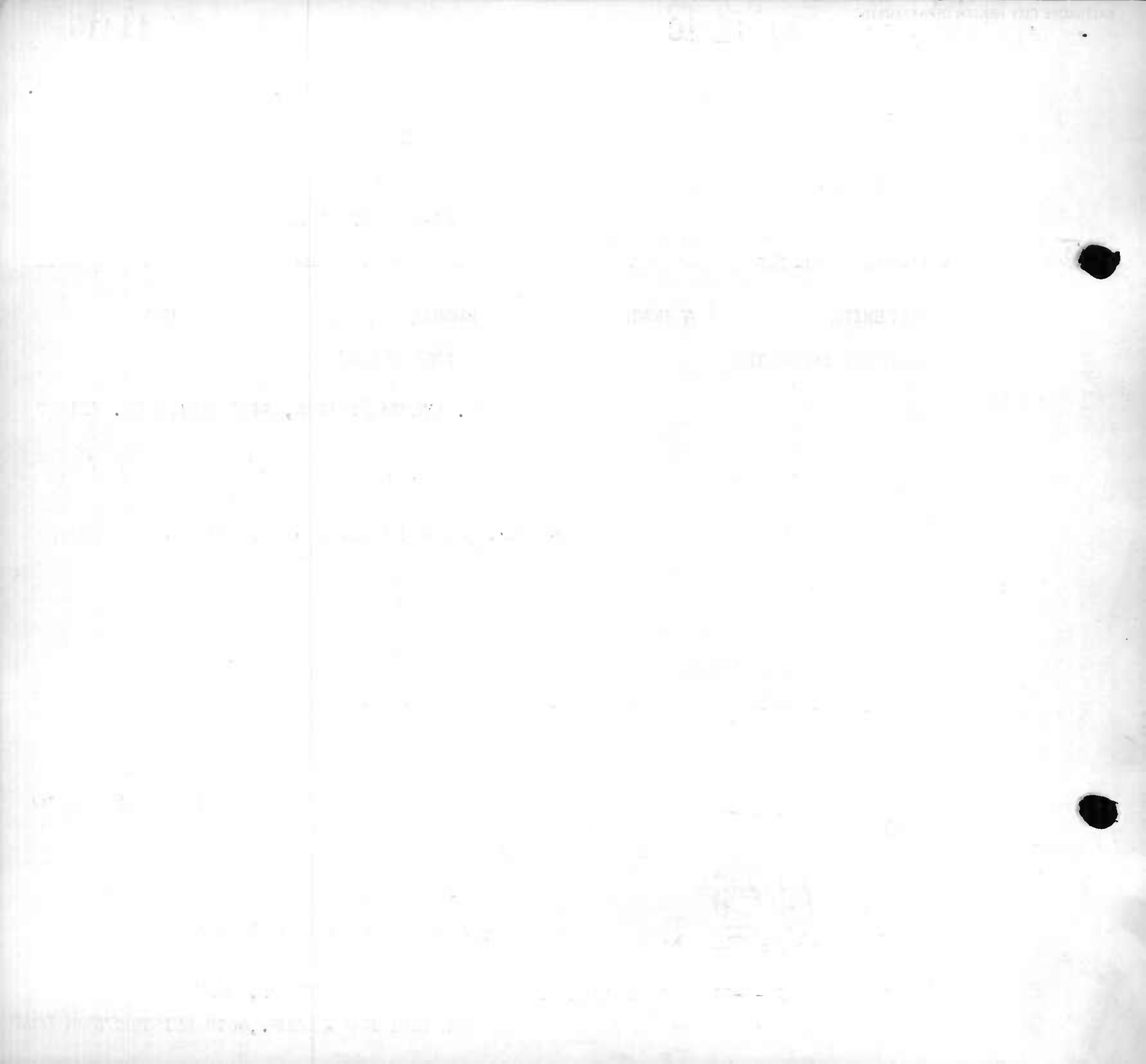
1-7-72 - Letter from - Office of the Chief Medical Examiner,
Ronald N. Kornblum, M.D.
Assistant Medical Examiner

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>S-300 71 11416</p> <p>BIRTH NO.</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 11416</p>	
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;">MINNIE SATOU</p>			<p>2. DATE AND HOUR OF DEATH</p> <p>DECEMBER 6, 1971 9 P.M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;">PALL MAIL NURSING HOME</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY BALTO</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 3404 RETLAW ROAD</p>		
<p>5. SEX</p> <p>FEMALE</p>	<p>6. RACE</p> <p>WHITE</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p> <p>84</p>	<p>9. AGE (In years last birthday)</p> <p>84</p>	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>HOUSEWIFE</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p>AT HOME</p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p>RUSSIA</p>	
<p>12. CITIZEN OF WHAT COUNTRY?</p> <p>USA</p>			<p>13. FATHER'S NAME</p> <p>ELCHONON SCHECHTER</p>		
<p>14. MOTHER'S MAIDEN NAME</p> <p>ROSE BEINSON</p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>NO</p>		
<p>16. SOCIAL SECURITY NO.</p>			<p>17. INFORMANT ADDRESS</p> <p>MRS. SYLVIA MELLMAN, 3404 RETLAW RD. #21207</p>		
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>009.21</p> <p>Acute Gastroenteritis</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>ASCVD, CBS and malnutrition</p> <p>years</p>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 12-6-1971 to Dec. 6-1971, that (I) (we) last saw the deceased alive on 12-6-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE</p> <p>Ardaiz</p>				<p>23B. DATE SIGNED</p> <p>12-7-71</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p>Jose ARDAIZ, M.D.</p>				<p>23D. ADDRESS</p> <p>2802 NORTH POINT ROAD, 21222</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>BURIAL</p>		<p>24B. DATE</p> <p>12-8-71</p>		<p>24C. NAME OF CEMETERY or CREMATORY</p> <p>BNAI ISRAEL</p>	
<p>24D. LOCATION (City, town, or county) (State)</p> <p>BALTIMORE, MARYLAND</p>		<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p>DEC 9 1971</p>			
<p>25B. NAME OF REGISTRAR</p> <p>Robert E. Taylor, M.D.</p>		<p>25C. FUNERAL DIRECTOR ADDRESS</p> <p>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500 71 11117				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11117	
BIRTH NO.				71 11117		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Bowen, Florence				2. DATE AND HOUR OF DEATH 12/4/71 1:14 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinal Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE MD.		B. COUNTY BALTIMORE	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3844 Dolfield Avon.			
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1911	9. AGE in years (last birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Bus Family		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Z. Marlowe				14. MOTHER'S MAIDEN NAME Alice C. Taylor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-22-7286		17. INFORMANT Edward Bowen		ADDRESS 3844 Dolfield Avon	
18. CAUSE OF DEATH 410.9 I				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-pulmonary arrest			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Cardiogenic shock. (C) Acute M.I. - GI bleeding			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				GI bleeding.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/2 19 71 to 12/4 19 71 that (I) (we) last saw the deceased alive on 12/4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Chapman MD				23B. DATE SIGNED 12/4/71		23C. PHYSICIAN'S NAME (Type) R. Michaelides MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-71		24C. NAME OF CEMETERY or CREMATORY MT Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS 3035 W. North	

11/20/20

Dear Mr. [Name]

I am writing to you regarding the [Topic]

I hope this letter finds you well. I am writing to you regarding the [Topic]

Very truly yours,

BIRTH NO.		REG. NO.	
H-45371 11418		71 11418	
1. NAME OF DECEASED (Type or Print) Willie T. Holland		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 7 71 2:33 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3929 Bareva Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 7 71 2:33 A. M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1511	
7. RACE Negro		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 3929 Bareva Avenue	
9. DATE OF BIRTH 9-24-1926		10. AGE (In years lost birthday) 45	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph W. Holland		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister & Truck Driver	
15. MOTHER'S MAIDEN NAME Treasie Goodman		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II	
17. SOCIAL SECURITY NO. 230-18-8892		18. INFORMANT ADDRESS Mrs. Thelma Holland 3929 Bareva Ave.	
19. 412.71 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-7-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-71	
24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Spitz, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	

11115

James M. Holman

Virginia

Station 1, York River

July 11, 1911

July 11, 1911

July 11, 1911

July 11, 1911

July 11, 1911

July 11, 1911

July 11, 1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		REG. NO. 71 11419	
BIRTH NO. B-260 71 11419		2. DATE AND HOUR OF DEATH Dec 2nd 1971 M.	
1. NAME OF DECEASED (Type or Print) Ella Baker		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1702	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1313 Division Street		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 8 1880 9. AGE (In years last birthday) 91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 10B. KIND OF BUSINESS OR INDUSTRY Pvt Family		11. BIRTHPLACE (State or foreign country) Baltimore country md 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Samuel Adams		14. MOTHER'S MAIDEN NAME Elizabeth Rhodes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-2966 17. INFORMANT Mrs Grace Thomas ADDRESS 2204 Basking Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) Arterio Sclerosis Heart Disease (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-2 19 70 to 12-2-71 19 71 that (I) (we) last saw the deceased alive on 12-2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE G. Franklin Phillips M.D.		23B. DATE SIGNED 12/7/71	
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips M.D.		23D. ADDRESS 558 McMechan St Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/71	
24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore County Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR R. E. J. J. J.	
25C. FUNERAL DIRECTOR Herbert F. Nutter		ADDRESS 3035 W. North Ave	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-432 71 11420		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11420	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		F I E L D S A D D I E G .		12/4/71 at 4:00 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland 46 730 Ashburton Bal., Md. 21216				A. STATE Maryland	
				B. COUNTY 1607	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2834 Riggs Avenue	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/14/90	9. AGE (in years last birthday) 81 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward H. Fields				14. MOTHER'S MAIDEN NAME Sarah E. Moore	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-3612		17. INFORMANT Miss Alice Fields 2834 Riggs Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonitis of Rt lung		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonitis of Rt lung 4 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Dehydration & Malnutrition.		(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic brain syndrome			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/2/71 to 12/4/71 that (I) (we) last saw the deceased alive on 12/4/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 12/4/71	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS Nutter Funeral Home 3035 W. North Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-71		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore Co. Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE					

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71 11421
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 11421

5-400
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Michael M. Slowe		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 4, 1971		Hour 1:35 AM
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year December 4, 1971		Hour 1:35 AM
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 5-23-1947		10. AGE (In years last birthday) 24		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF USA		13. FATHER'S NAME Walter Slowe		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder
15. MOTHER'S MAIDEN NAME Frances Lee		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-46-8132
18. INFORMANT Barbara Slowe		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Manual strangulation. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 12-8-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? front of 307 Harlem Lane
22D. TIME OF INJURY (APPROX.) 12, 4, 1971, 1:30 AM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? involved in altercation
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 4, 1971
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.
24D. LOCATION (City, town, or county) (State) Baltimore County MD		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.
25C. FUNERAL DIRECTOR Nutter Funeral Home		25D. ADDRESS 3035 W. North		25E. ADDRESS AUG

VS 151-REV. 1/1/68

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11422</u>	
BIRTH NO. <u>0-520 71 11422</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ELAINE OWENS</u>		2. DATE AND HOUR OF DEATH <u>5 DEC 71</u> <u>2:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>2047</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>120 S. Culver Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1921</u>	9. AGE (In years last birthday) <u>50</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Family</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Bright</u>		14. MOTHER'S MAIDEN NAME <u>Annie Stevens</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-18-8312</u>		17. INFORMANT <u>Mr. Moses Owens 120 S. Culver Street</u>	
18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ca Cernix</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0 6 / 71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>pelvic mass lesion</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Nov 20</u> 19 <u>71</u> to <u>Dec 5</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>5 Dec</u> 19 <u>71</u> and that (in my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Barbara Azz MD</u>		23B. DATE SIGNED <u>5 Dec 71</u>			
23C. PHYSICIAN'S NAME (Type) <u>BARBARA Azz</u>		23D. ADDRESS <u>U. of Md. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-10-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore</u>		24E. STATE <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE</u>	

Handwritten text, possibly a signature or date, located in the upper right quadrant of the page.

BIRTH NO.		71 11423		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		71 11423		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH				3. DATE PRONOUNCED DEAD			
FRED S. BOYD				Known <input type="checkbox"/> Estimated <input type="checkbox"/>				Month Day Year Hour			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				A. STATE			
FULL NAME OF HOSPITAL OR INSTITUTION				B. COUNTY				Md.			
00 2nd floor 606 Washington Blvd.				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
male				Balto.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX				7. RACE				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
white				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
9. DATE OF BIRTH				10. AGE (in years ?)				11. BIRTHPLACE (State or foreign country)			
1-22-11				51				Bris Tol. Tenn			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
U.S.				James A. Boyd							
15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.			
Martha Jane Adams				yes				4-21-44-6-11-46 413160181			
18. INFORMANT				19. CAUSE OF DEATH				20. DATE OF OPERATION			
Clyde Williams				Asphyxia				21. AUTOPSY? (Yes or No)			
606 Washington Blvd.								yes			
22. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				24. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
				home				606 Washington Blvd. 2101			
25. TIME OF INJURY (APPROX.)				26. INJURY OCCURRED				27. HOW DID INJURY OCCUR?			
12-5-71				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Choked on bolus of food.			
28. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				29. ACTUAL SIGNATURE				30. DATE SIGNED			
Russell S. Fisher, M.D.				12-6-71							
31. BURIAL CREMATION, REMOVAL (Specify)				32. DATE				33. NAME OF CEMETERY or CREMATORY			
Burial				12-10-71				Loudoun DB			
34. DATE REC'D BY HEALTH DEPT.				35. NAME OF REGISTRAR				36. FUNERAL DIRECTOR			
DEC 10 1971				Charles E. Fisher				Charles E. Hughes			
1532				1532				1532			

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11153

11-22-11

James M. Boyd

11-22-11

11-22-11

11-22-11

11-22-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11424	
CERTIFICATE OF DEATH					
BIRTH NO. B-424		11424			
1. NAME OF DECEASED (Type or Print) BLACKLEY MARY (DUPPINS)			2. DATE AND HOUR OF DEATH 12-7-71 9:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1402		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1739 McCulloh St		
5. SEX FEMALE	6. RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-37	9. AGE (In years last birthday) 34	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10B. KIND OF BUSINESS OR INDUSTRY Dry Cleaning		11. BIRTHPLACE (State, or foreign country) Virginia	
12. COUNTRY OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Norman Bibbs			14. MOTHER'S MAIDEN NAME Naomi Blackley		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-32-3882		17. INFORMANT Mrs Mary Cheatham, 561 Laurens St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Indurational Hemorrhage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hyperensive cerebrovascular disease		
			(B) No eclampsia of pregnancy		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-5-71 to 12-7-71 that (I) (we) last saw the deceased alive on 12-7-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE U. SANGKUM			23B. DATE SIGNED 12-7-71		
23C. PHYSICIAN'S NAME (Type) U. SANGKUM			23D. ADDRESS Maryland General Hospital, Balto. Md 2120		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/71		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
24D. LOCATION Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert F. Taylor, Md.		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	

71 11425		BALTIMORE CITY HEALTH DEPARTMENT		71 11425 ✓	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. _____	
1. NAME OF DECEASED (Type or Print) Crystal Hendley		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour December 5, 1971 6:15 A.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 5, 1971 6:15 A.M.			
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Nov. 8, 1971		10. AGE (In years last birthday) 27		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Charles		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1702	
15. MOTHER'S MAIDEN NAME Geraldine		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mother		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxiation. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1322 Eutaw Place 1702	
22D. TIME OF INJURY (APPROX.) 12/5/71 6:00 AM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? entangled in blankets in mother's bed.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 5, 1971	
24A. BURIAL CREMATION, REMOVAL. (Specify) Burial		24B. DATE 12/10/71		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A County Md		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North Ave			

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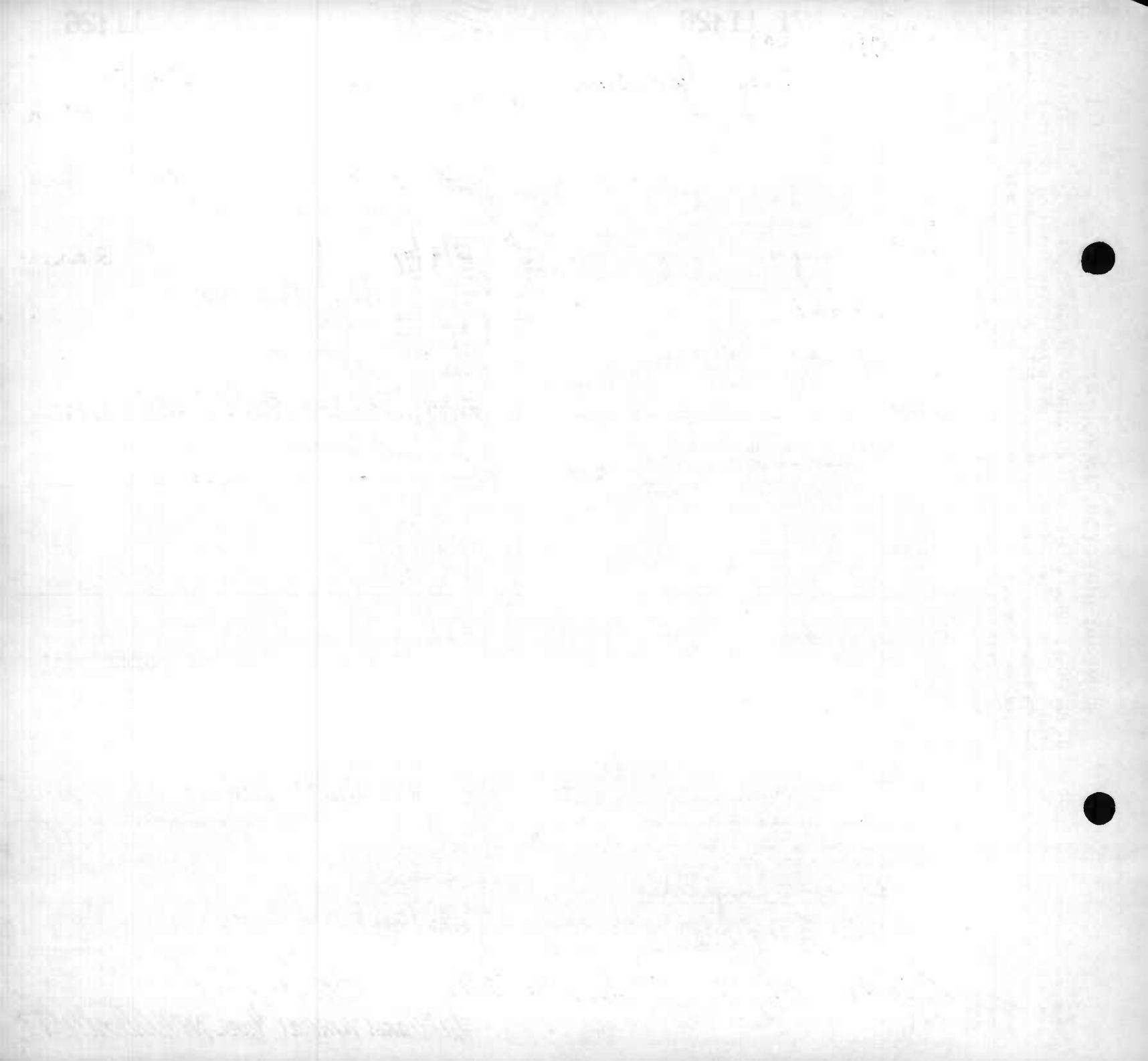
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 11426	
<div style="display: flex; justify-content: space-between;"> J. 525 71 11426 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Baby Johnson			2. DATE AND HOUR OF DEATH 10:45 pm 12/4/71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: Sinai Hospital of Baltimore (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Baltimore B. COUNTY: Maryland C. CITY OR TOWN: Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: 4006 Oakford Ave # N		
5. SEX male	6. RACE neg	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/71	9. AGE (In years (last birthday)) 2 hrs	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sinai Hosp.; Balto., MD	
13. FATHER'S NAME William Johnson			14. MOTHER'S MAIDEN NAME Vivian Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Wm. Johnson 4006 Oakford Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Immaturity			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 4 9:45 am 1971 to 12/4/71 10:45 pm, that (I) (we) last saw the deceased alive on 10:45 pm 12/4/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Opheila Zarzule			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Opheila Zarzule
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12/9/71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971			25B. NAME OF REGISTRAR William E. Taylor, R.D.		25C. FUNERAL DIRECTOR Williams Funeral Home 3199 Broadway St



P-620

71 11427

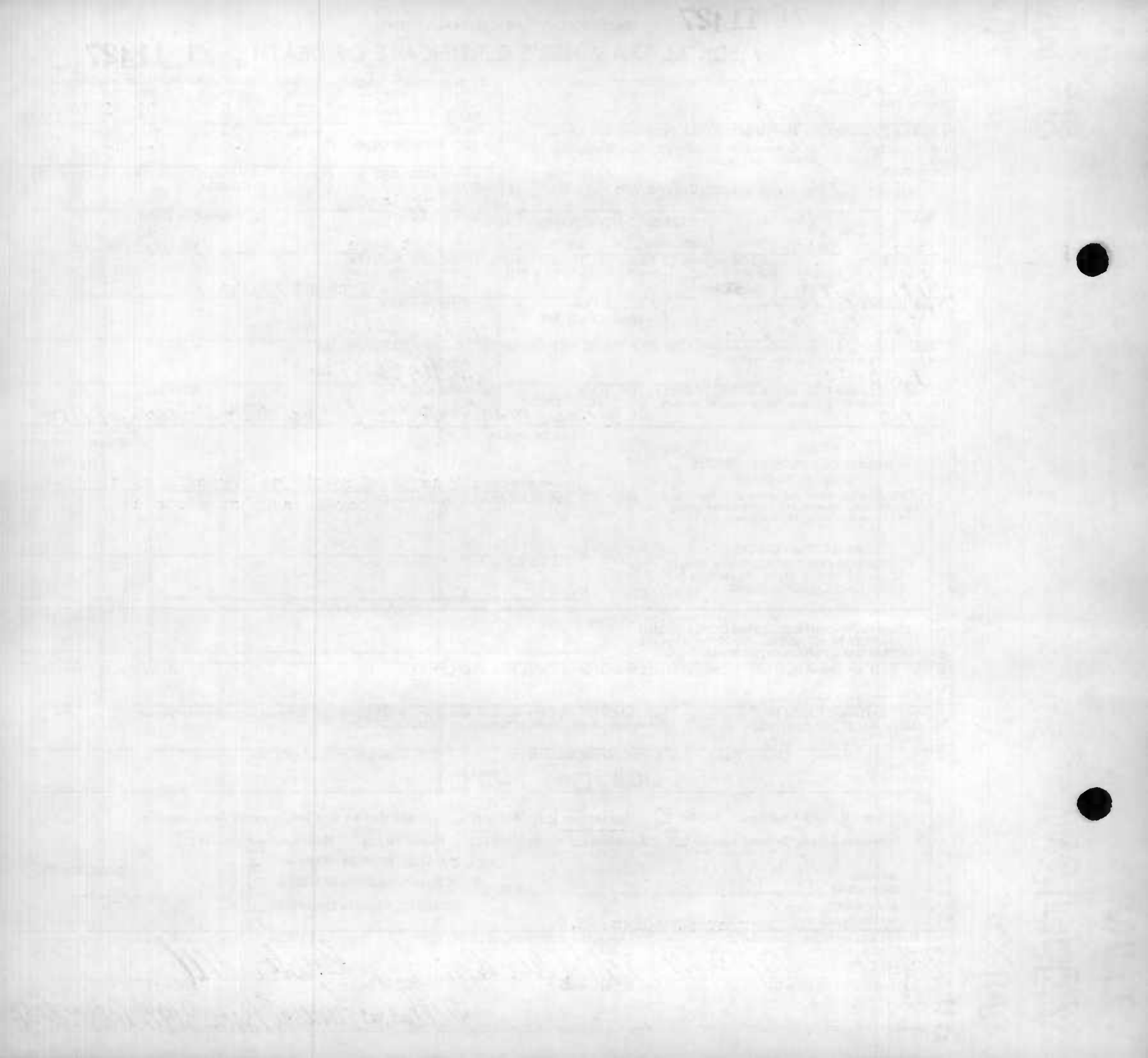
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 11427

BIRTH NO.

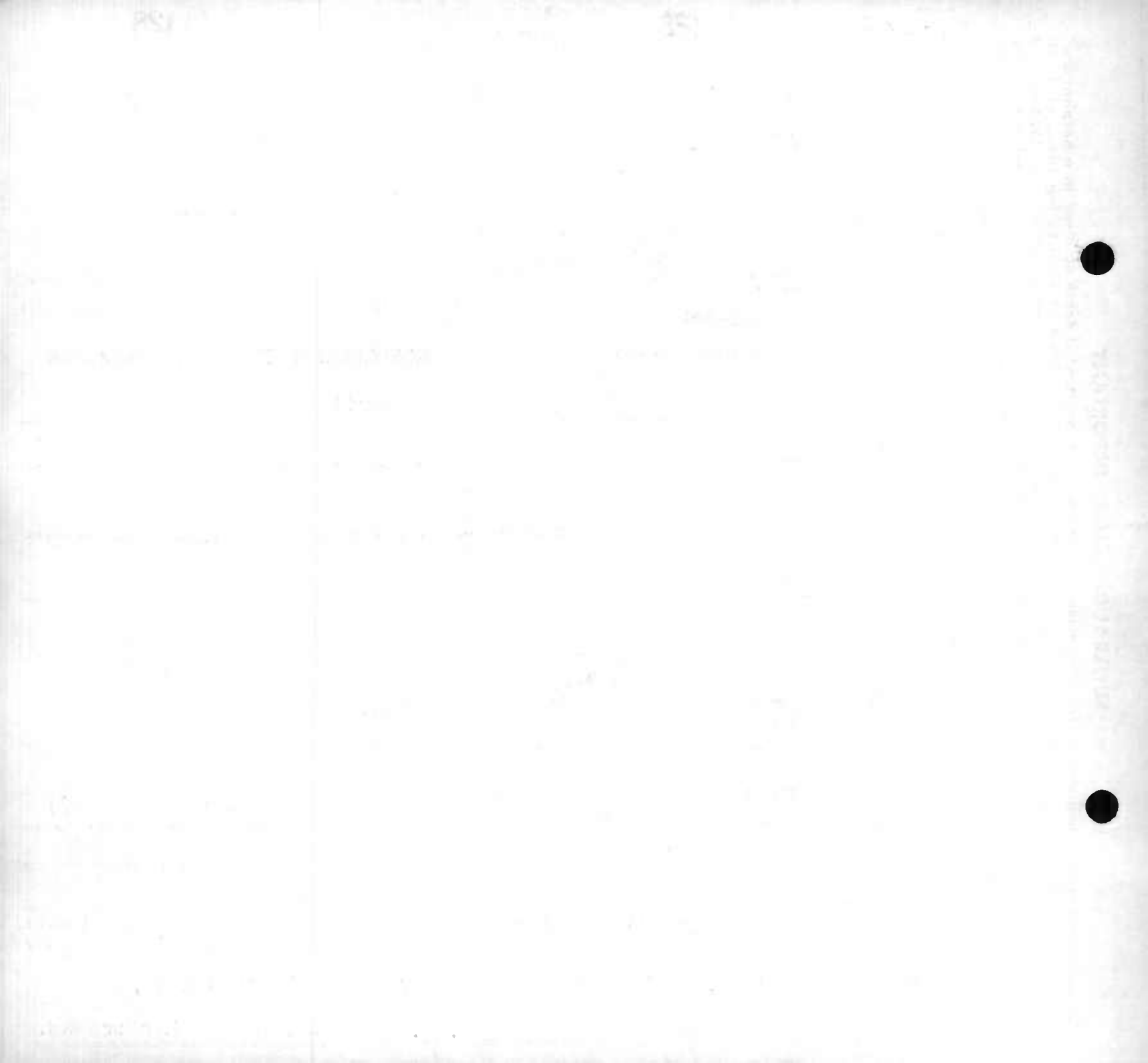
1. NAME OF DECEASED (Type or Print) Fred Price				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 7 71 3:10 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 524 N. Fremont Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 7 71 3:10 A. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH April 12, 1921				10. AGE (in years last birthday) 50		11. BIRTHPLACE (State or foreign country) Amelia Co Va.	
12. CITIZEN OF WHAT COUNTRY? Unknown				13. FATHER'S NAME Unknown			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				15. MOTHER'S MAIDEN NAME Unknown			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 230-226899		18. INFORMANT Costella Dunn	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and hypertensive				20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiovascular disease			
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				22. DUE TO, OR AS A CONSEQUENCE OF:			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				24. DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No				22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-7-71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/13/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. Md.		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR J. B. ...		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3199 Schroeder St.	



FUNERAL DIRECTOR: IMPORTANT

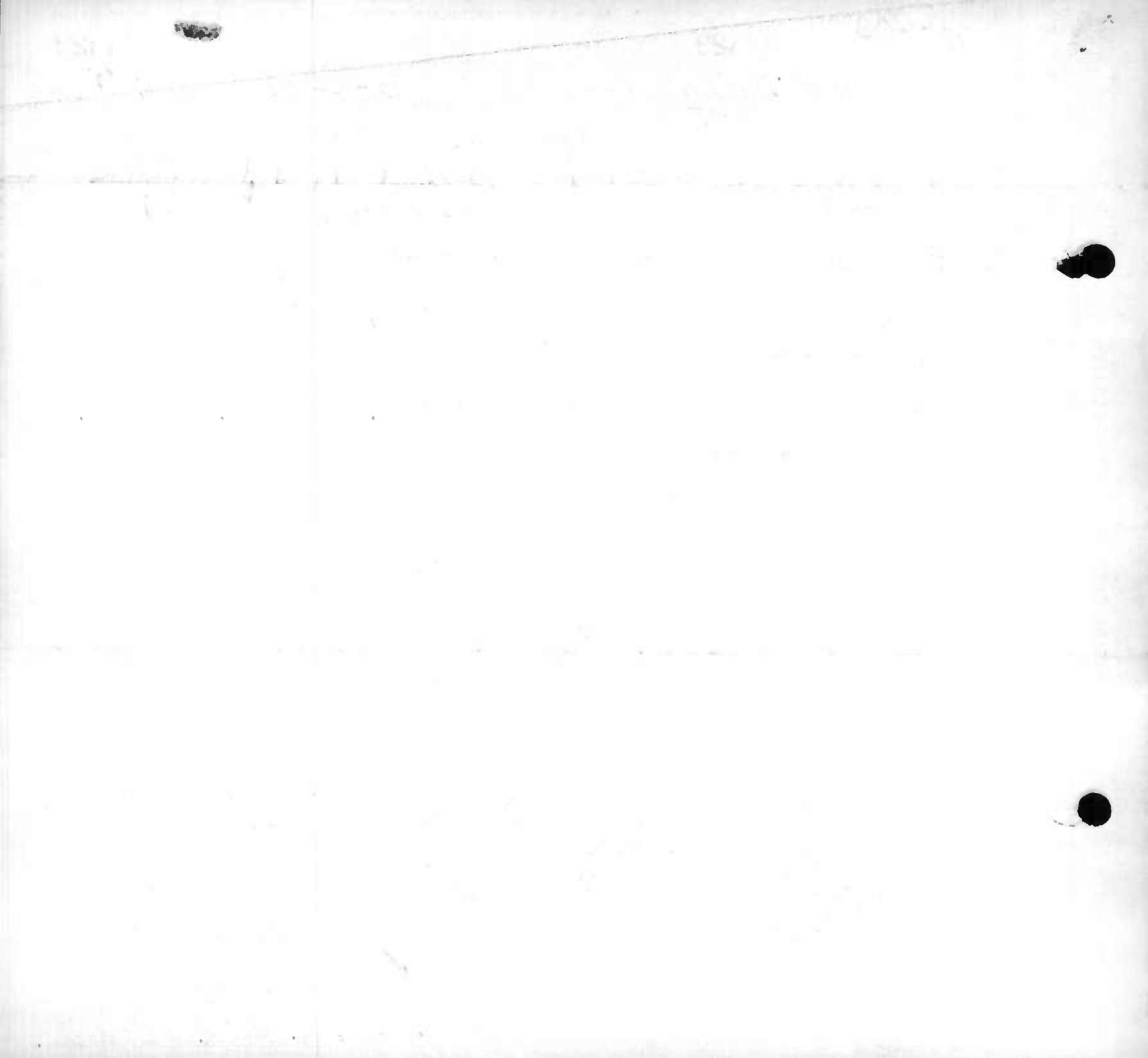
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 11428	
T-000 11428		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
THAU, ERNA M. (Mrs EDWARD)		Dec 6 1971 2:03 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE & COUNTY			
The Union Memorial Hospital		Maryland Baltimore			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		City		YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		2816 Garnet Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-30-12	58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Germany	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
OTTO BUCKHOLZ		XXXXXXXXXX Elizabeth Petranek		American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		212 07 7039		family	
18. 562.1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		2 weeks	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) Bleeding Diverticulosis of colon		2 months	
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
Nov 3 1971		Subtotal colectomy		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from NOV 2 1971 to Dec 6 1971 that (I) (we) last saw the deceased alive on Dec 6 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Teh-ching Wang MD					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
TEH-CHING WANG MD				33rd + Calvert Street Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		Dec. 10, 1971		Oaklawn Cemetery	
				Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 10 1971		C. F. Evans & Son		8802 Harford Rd.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11430	
BIRTH NO. D-540 71 11430					
1. NAME OF DECEASED (Type or Print) MARY DANIEL (ALSO MARY HORSEMAN)			2. DATE AND HOUR OF DEATH December 6, 1971 7:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2102		
5. SEX Female			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5-30-1907		9. AGE (In years last birthday) 64		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME George P. Charles			14. MOTHER'S MAIDEN NAME Anna Zemetis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-14-7399		17. INFORMANT ADDRESS Mr. Gerald Thomas Horseman, 1346 Glyndon Ave.
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause I(A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertensive Cardio Vascular DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-14 19 68 to 12-6 19 71 that (I) (we) last saw the deceased alive on 12-4 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (dtd) (did not) view the body after death.					
23A. SIGNATURE John P. Urlock, Jr. DEGREE				23B. DATE SIGNED 12/8/71	
23C. PHYSICIAN'S NAME (Type) John P. Urlock, Jr. DEGREE				23D. ADDRESS 1227 Washington Blvd., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-1971		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Gabley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861.

2. The second part is a report from the Secretary of the Treasury, dated January 1, 1861.

3. The third part is a report from the Secretary of the Interior, dated January 1, 1861.

4. The fourth part is a report from the Secretary of the Navy, dated January 1, 1861.

5. The fifth part is a report from the Secretary of the War, dated January 1, 1861.

6. The sixth part is a report from the Secretary of the State, dated January 1, 1861.

7. The seventh part is a report from the Secretary of the War, dated January 1, 1861.

8. The eighth part is a report from the Secretary of the Navy, dated January 1, 1861.

9. The ninth part is a report from the Secretary of the War, dated January 1, 1861.

10. The tenth part is a report from the Secretary of the Navy, dated January 1, 1861.

11. The eleventh part is a report from the Secretary of the War, dated January 1, 1861.

12. The twelfth part is a report from the Secretary of the Navy, dated January 1, 1861.

13. The thirteenth part is a report from the Secretary of the War, dated January 1, 1861.

14. The fourteenth part is a report from the Secretary of the Navy, dated January 1, 1861.

15. The fifteenth part is a report from the Secretary of the War, dated January 1, 1861.

16. The sixteenth part is a report from the Secretary of the Navy, dated January 1, 1861.

17. The seventeenth part is a report from the Secretary of the War, dated January 1, 1861.

18. The eighteenth part is a report from the Secretary of the Navy, dated January 1, 1861.

19. The nineteenth part is a report from the Secretary of the War, dated January 1, 1861.

20. The twentieth part is a report from the Secretary of the Navy, dated January 1, 1861.

21. The twenty-first part is a report from the Secretary of the War, dated January 1, 1861.

22. The twenty-second part is a report from the Secretary of the Navy, dated January 1, 1861.

23. The twenty-third part is a report from the Secretary of the War, dated January 1, 1861.

24. The twenty-fourth part is a report from the Secretary of the Navy, dated January 1, 1861.

25. The twenty-fifth part is a report from the Secretary of the War, dated January 1, 1861.

26. The twenty-sixth part is a report from the Secretary of the Navy, dated January 1, 1861.

27. The twenty-seventh part is a report from the Secretary of the War, dated January 1, 1861.

28. The twenty-eighth part is a report from the Secretary of the Navy, dated January 1, 1861.

29. The twenty-ninth part is a report from the Secretary of the War, dated January 1, 1861.

30. The thirtieth part is a report from the Secretary of the Navy, dated January 1, 1861.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]	
W-623 71 11431		71 11431	
BIRTH NO. OR RANDOLPH T. WRIGHT		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WRIGHT, RANDOLF T.		2. DATE AND HOUR OF DEATH 12/7/71 508 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE VIrginia B. COUNTY V4S	
FULL NAME OF HOSPITAL OR INSTITUTION 38		C. CITY OR TOWN New Church D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		E. STREET AND NUMBER Box 5K112	
6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4/16/38		9. AGE (in years last birthday) 33	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Campbell Soup Co.		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIrginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERMAN R. WRIGHT		14. MOTHER'S MAIDEN NAME JANE MISTER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 229-46-0166	
17. INFORMANT admission Record		ADDRESS	
18. 038.9 14250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Rectal Bleeding		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Renal failure		(B) DUE TO, OR AS A CONSEQUENCE OF: 5 days	
(C) Bloodstream & pharyngitis		30 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes, Renal failure, Rhinocerebral pharyngitis			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) none	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? none	
22. I certify that (I) (this hospital) attended the deceased from 10/31 19 71 to 12/7 19 71 that (I) (we) last saw the deceased alive on 12/7 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Fred R. Eilber MD		23B. DATE SIGNED 12/7/71	
23C. PHYSICIAN'S NAME (Type) Fred R. Eilber MD		23D. ADDRESS University Hospital, Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/71	
24C. NAME OF CEMETERY OR CREMATORY Downings Cemetery		24D. LOCATION (City, town, or county) (State) Oak Hall, Va.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

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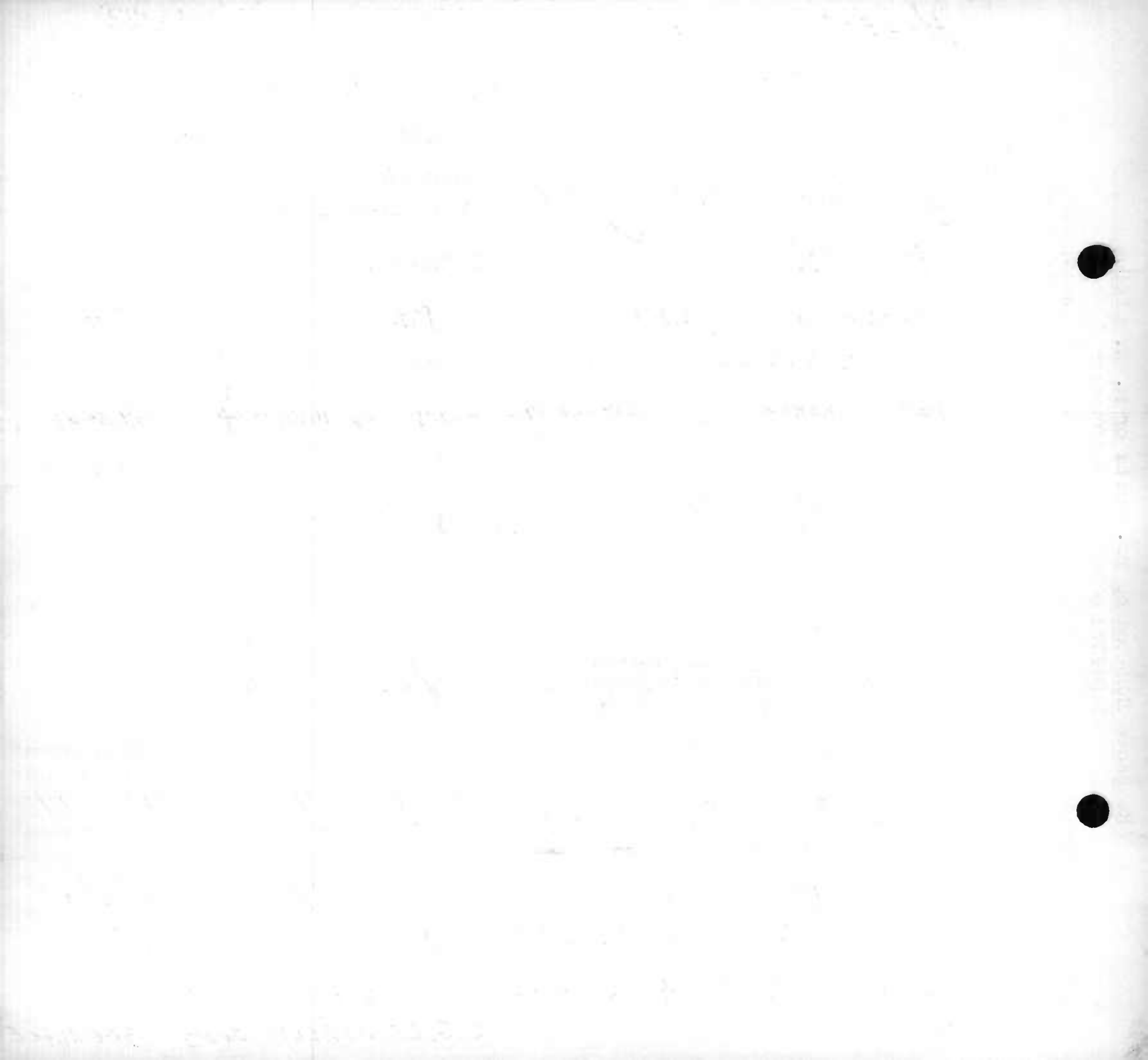
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10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 11432	
CERTIFICATE OF DEATH				REG. NO. 71 11432	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Hastings, Royward R.</i>		2. DATE AND HOUR OF DEATH <i>12/7/71 11 A M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundle</i>		5. STREET AND NUMBER <i>726 Genessee Street</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hosp</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Annapolis</i>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>726 Genessee Street</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/28/30</i>	9. AGE (in years last birthday) <i>41</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LOCKSMITH</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>NAVF</i>		11. BIRTHPLACE (State or foreign country) <i>PA.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Roy Hastings</i>		14. MOTHER'S MAIDEN NAME <i>Grace Houck</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <i>YES KOREA</i>		16. SOCIAL SECURITY NO. <i>214-26-9412</i>		17. INFORMANT <i>MARY LOU HASTINGS</i>	
18. <i>412.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cardiac Arrest</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD H/O MI X 3</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		CAUSE OF DEATH <i>Cardiac Arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11 AM</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>12/7/71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cardio angiography</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <i>11/24</i> 19 <i>71</i> to <i>12/7</i> 19 <i>71</i> that (1) (my) last saw the deceased alive on <i>12/7</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>LE Rambler MD</i>		23B. DATE SIGNED <i>12/7/71</i>		23C. PHYSICIAN'S NAME (Type) <i>LE Rambler MD</i>	
23D. ADDRESS <i>Johns Hopkins Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12/11/71</i>	
24C. NAME of CEMETERY or CREMATORY <i>HOLLY HILL</i>		24D. LOCATION <i>BALTO. MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 10 1971</i>	
25B. NAME OF REGISTRAR <i>John E. Jolley, M.D.</i>		25C. FUNERAL DIRECTOR <i>J.G. CONNELLY SONS</i>		25D. ADDRESS <i>300 MAce</i>	



FUNERAL DIRECTOR: IMPORTANT

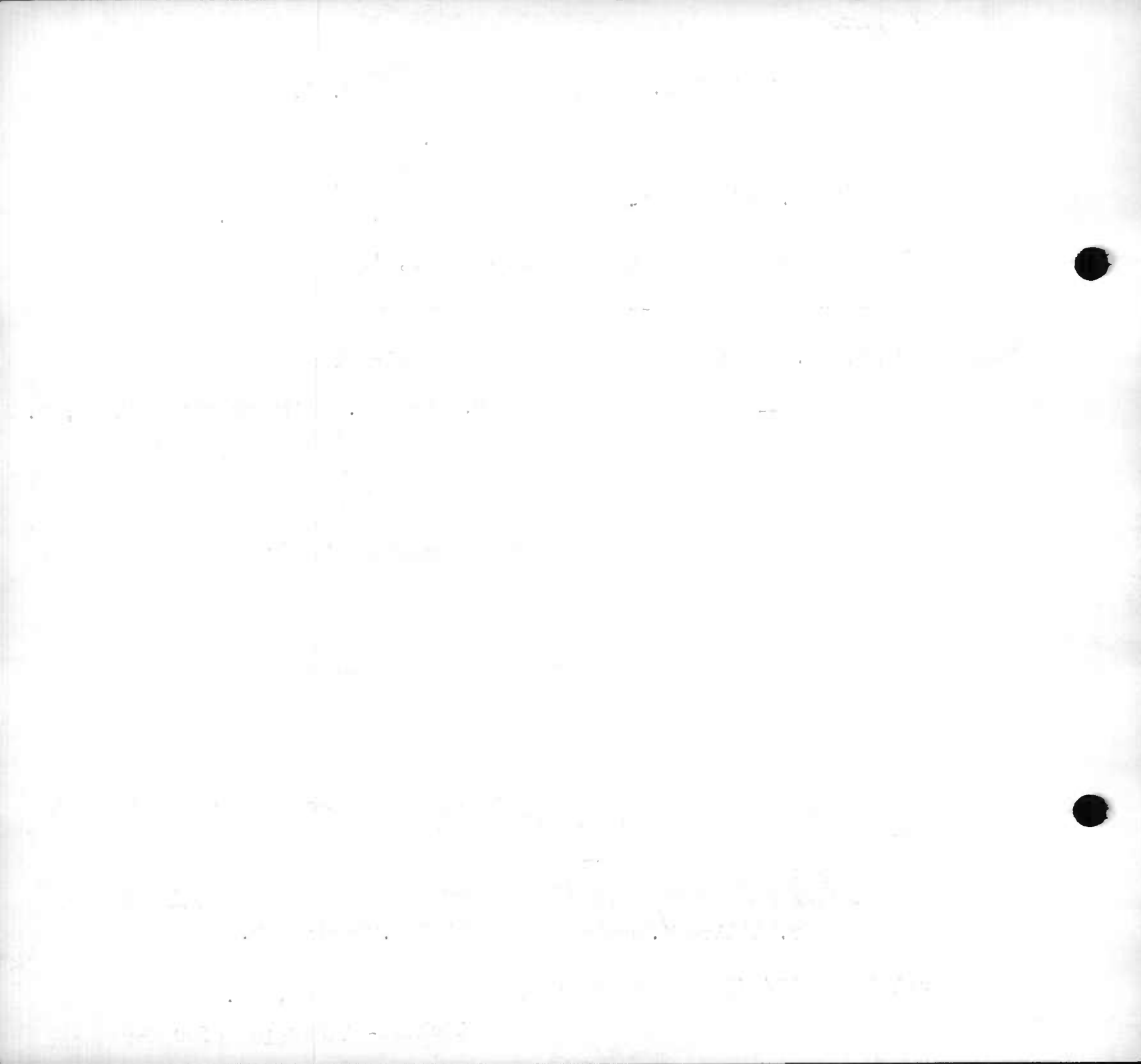
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11433	
G-620 71 11433		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Jean George		2. DATE AND HOUR OF DEATH 12/6/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY 2711			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-12-19		9. AGE (In years lost birth day) 52		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) md.	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME THOMAS S. GEORGE		14. MOTHER'S MAIDEN NAME ESTHER RIDGELY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. 220-07-7208		17. INFORMANT THOMAS S. GEORGE	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		ADDRESS 102 W. WILLIAM ST. SALISBURY MD.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF:					
(B) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-29 19 71 to 12-6 19 71 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juan M. Calderon		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON M.D.	
23D. ADDRESS		23E. DATE REC'D BY HEALTH DEPT. DEC 10 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/8/71		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. FUNERAL DIRECTOR Mitchell-Wiedefeld Home			
25B. NAME OF REGISTRAR Salisbury, M.D.		25C. ADDRESS 6500 York Road, Balto. 21212			

FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

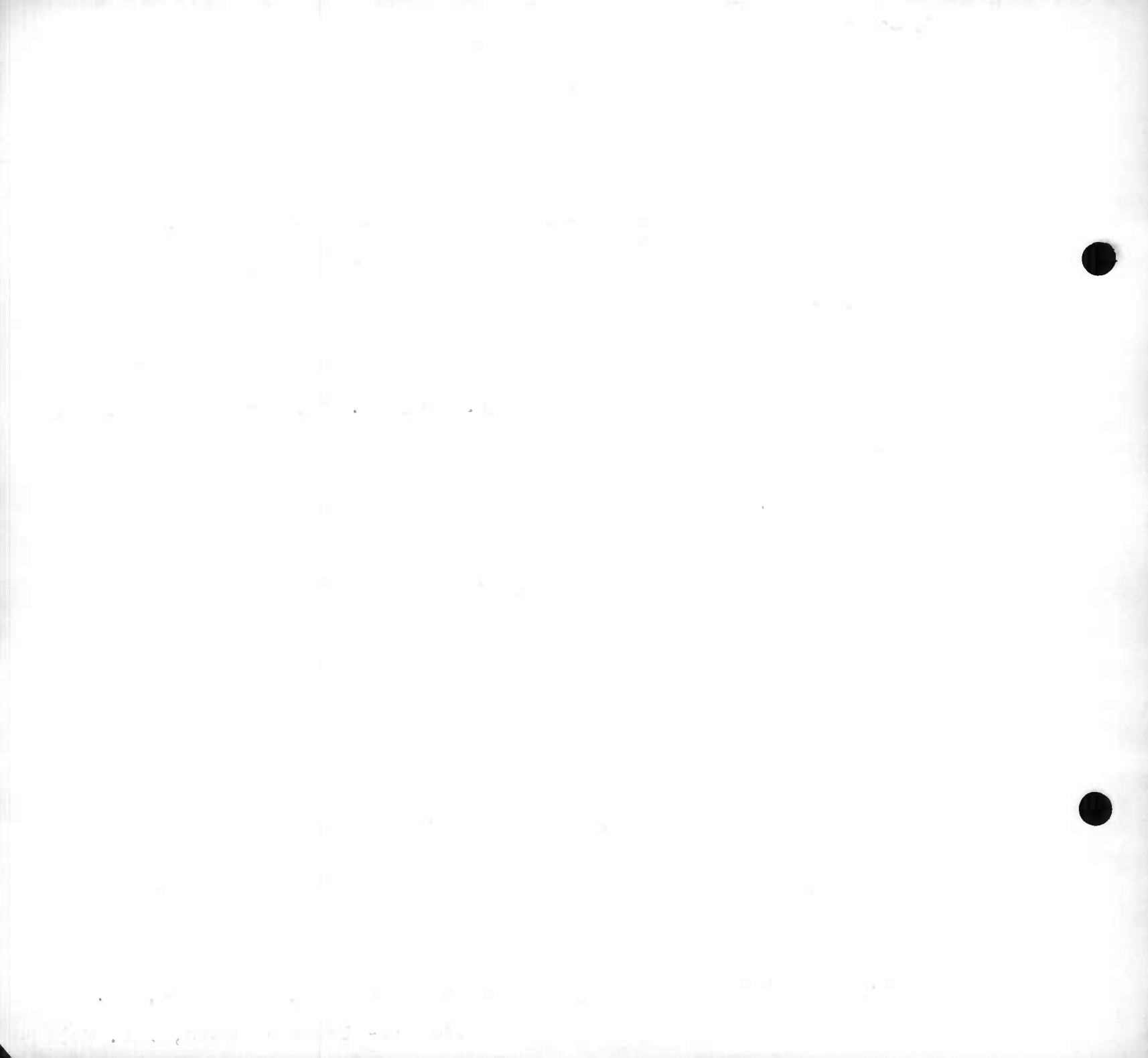
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11434	
G-654 71 11434		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Elizabeth H. Gramly		Dec. 5, 1971		4 45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 2520 N. Calvert St.		A. STATE Md.		B. COUNTY	
		C. CITY OR TOWN Baltimore,		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2520 N. Calvert St.					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, '79	9. AGE (in years last birthday) 92	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Francis X. Hooper		14. MOTHER'S MAIDEN NAME Adela King			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Mr. Frank H. Medenger Short Hills, N. J.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, esthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Basal Intestinal Hemorrhage</i> <i>Arterial Atherosclerosis</i> <i>Directly</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Spontaneous Rupture of</i> <i>Hypertension with Cardiac</i> <i>Arteriosclerosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF <i>Coronary Artery Disease</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days</i> <i>Gradual onset</i> <i>Gradual</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 1946</i> to <i>Dec 5th</i> 1971 that (I) (we) lost saw the deceased alive on <i>Dec 5</i> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. H. Woody</i>		23B. DATE SIGNED 12-7-71			
23C. PHYSICIAN'S NAME (Type) Dr. William H. Woody		23D. ADDRESS 3105 N. Charles St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/71		24C. NAME OF CEMETERY OR CREMATORY Prospect Hill	
24D. LOCATION Towson, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR <i>Reed</i>		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld 6500 York Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

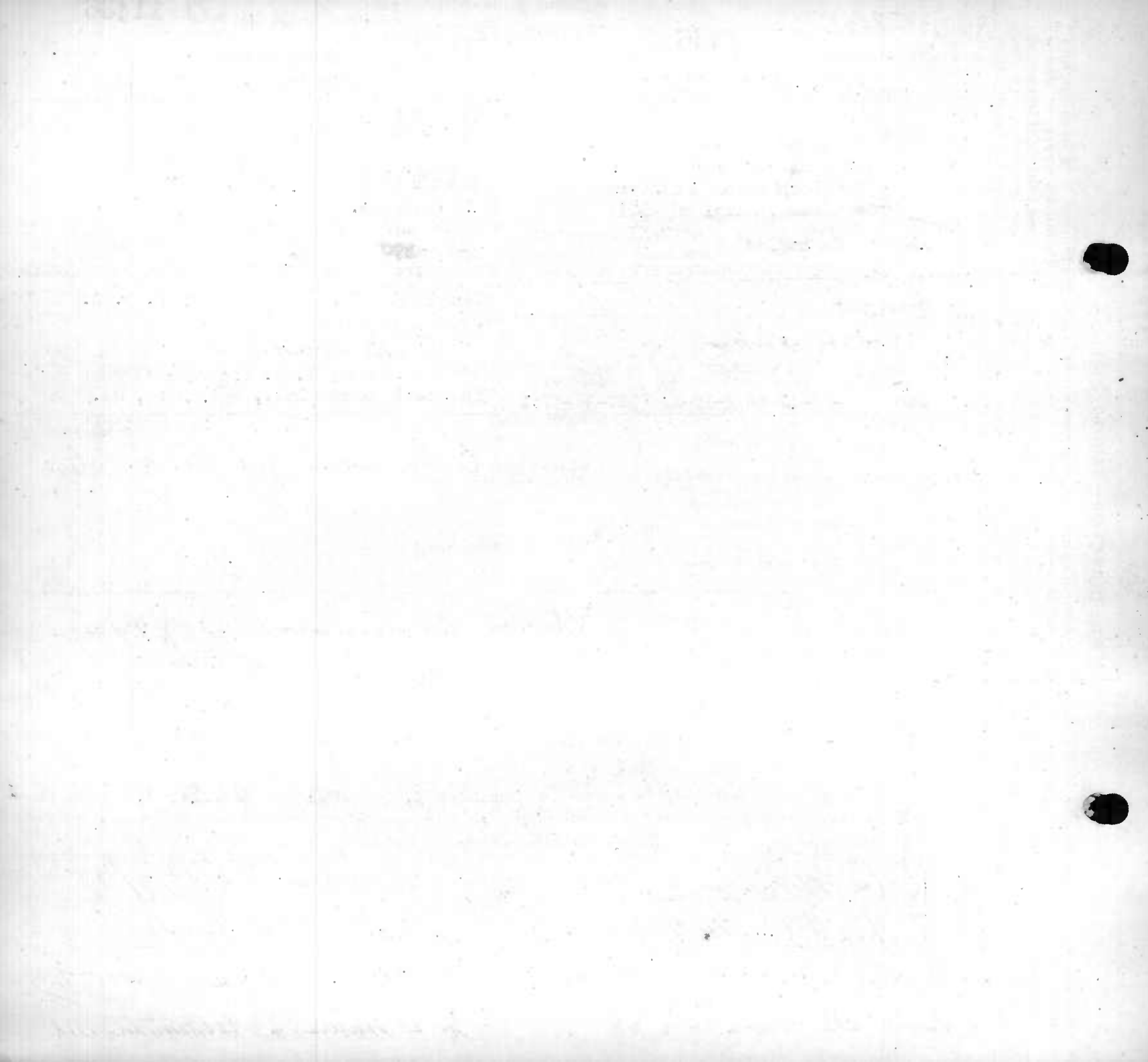
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11435	
C-423 71 11435		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ANNA F CHILCOAT		2. DATE AND HOUR OF DEATH DECEMBER 4 1971 7:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2739	
5. SEX F		6. RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06-28-1900	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		9. AGE (In years last birthday) 71	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
13. FATHER'S NAME DUSTIN FROME		12. CITIZEN OF WHAT COUNTRY USA	
14. MOTHER'S MAIDEN NAME MAUDE SCHILLINGSBERG		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Alvin S. Shilcoat 1348 Pentridge Rd	
18. 695 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) UREMIE COMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC PYELONEPHRITIS CHRONIC CYSTITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/3 19 71 to 12/4 19 71 that (I) (we) last saw the deceased alive on 12/4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED 12/4/71	
23C. PHYSICIAN'S NAME (Type) CEAR VILLANAR		23D. ADDRESS 33rd. and Calvert	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/71	
24C. NAME OF CEMETERY or CREMATORY Odd Fellows Cemetery		24D. LOCATION (City, town, or county) (State) Rock Hill Furnace, Pa.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Valley, M.D.	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		25D. ADDRESS 6500 York Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

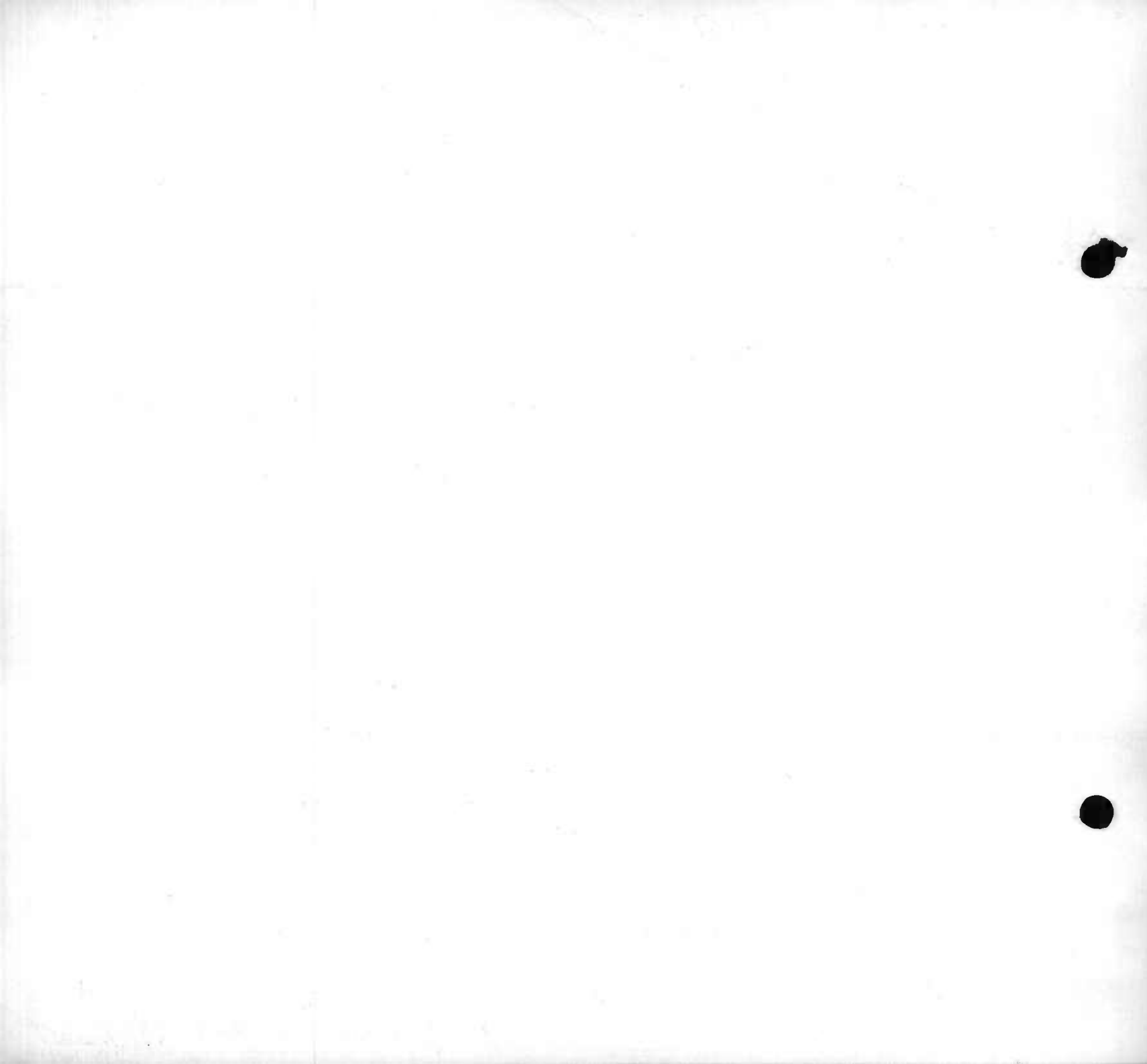
<div style="display: flex; justify-content: space-between;"> 1-520 71 11436 </div>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11436	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JUNG, GEORGE PHILIP				2. DATE AND HOUR OF DEATH December 7, 1971 1:15 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21211				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Carroll 5600 C. CITY OR TOWN Westminster D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 24 Poole Rd.			
5. SEX Male		6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-27-1890	
9. AGE (In years last birthday) 81		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME GEORGE JUNG				14. MOTHER'S MAIDEN NAME LOUISE SCHNEIDER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1-14-41 to 8-10-44		16. SOCIAL SECURITY NO. 387-36-5751		17. INFORMANT Records V. A. Hospital ADDRESS 3900 Loch Raven Blvd., Baltimore, Md.			
18. 429.94 188 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or compulsion which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular collapse minutes. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Bladder Carcinoma.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from December 3, 1971 to December 7, 1971, that (X) (we) last saw the deceased alive on December 7, 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. W. Mellinger, M.D.				23B. DATE SIGNED 12/7/71		23C. PHYSICIAN'S NAME (Type) Richard W. Mellinger, M.D.	
23D. ADDRESS Lock Raven V.A. Hosp.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12-11-71		24C. NAME OF CEMETERY or CREMATORY ST. THOMAS PARISH CEMETERY		24D. LOCATION (City, town, or county) (State) DWINGS MILLS BALTO CO. MD.			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR J. E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS J. E. Taylor, Jr. Westminster, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11437	
<div style="display: flex; justify-content: space-between;"> P-200 71 11437 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES F. POKE		2. DATE AND HOUR OF DEATH DEC 8 1971 11:31 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2102		
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. HOSP.			C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38			E. STREET AND NUMBER 1204 W. CROSS ST.		
5. SEX ♂	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/88	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10B. KIND OF BUSINESS OR INDUSTRY cabinetry		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Henry Poke			14. MOTHER'S MAIDEN NAME Mary?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-2211-A		17. INFORMANT Mrs. Gladys Poke	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 437.9 14-018.9		CAUSE OF DEATH (A) IMMEDIATE CAUSE cerebral arterial sclerosis DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). possible military TB		days?	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (1) (this hospital) attended the deceased from 12/4/71 19 71 to 12/8 19 71 that (1) (we) last saw the deceased alive on 12/8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dan McDougal				23B. DATE SIGNED 12/8/71	
23C. PHYSICIAN'S NAME (Type) DAN H. MCDUGAL MD				23D. ADDRESS UNIV. MD. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John J. C. Evans & Son Inc.			
25D. ADDRESS 98 Hollis St.		25E. CITY Baltimore, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 71 11438		BALTIMORE CITY HEALTH DEPARTMENT		71 11438	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) BECK, CATHERINE		2. DATE AND HOUR OF DEATH Dec 18 / 1971 340 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2670			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY Hospital 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Cross & Blackwell		8. DATE OF BIRTH 10-28-91	
13. FATHER'S NAME Edward Einersen		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) 75	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-4206		17. INFORMANT BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolism and ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Fracture on hip		DUE TO, OR AS A CONSEQUENCE OF: Fracture on hip		1 month and 2 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASCVD - 10 months prior to death					
19A. DATE OF OPERATION 11/2/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Genettt Hip maling		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Initially medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Eastern Ave 26-11	
21D. TIME OF INJURY (Approx.) 11-1-71 Noon		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Tripped over a dog - fell	
22. I certify that (X) (this hospital) attended the deceased from 11-1-71 to 8-Dec-71 and that (X) (we) last saw the deceased alive on Dec 8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.		23A. SIGNATURE Luis Carrillo		23B. DATE SIGNED 8/Dec/1971	
23C. PHYSICIAN'S NAME (Type) Luis Carrillo		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-1971		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Vaden, M.D.	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		25D. ADDRESS 1901-07 Eastern Ave.			

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FUNERAL DIRECTOR: IMPORTANT

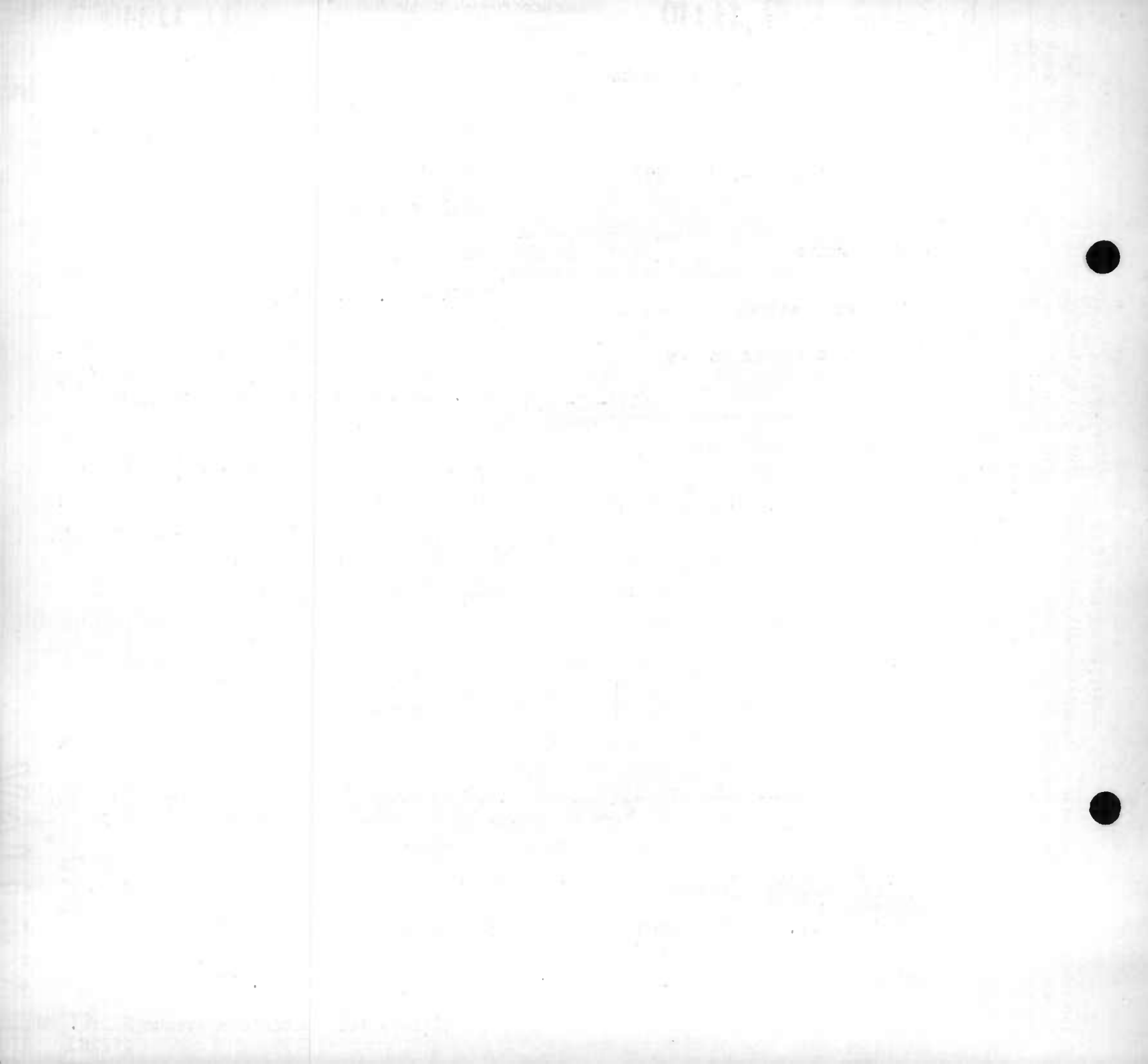
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-652		71 11439		BALTIMORE CITY HEALTH DEPARTMENT		71 11439	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				LORENZO HARRINGTON		2. DATE AND HOUR OF DEATH 12-7-71 2:00 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MARYLAND		B. COUNTY 833	
THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33				E. STREET AND NUMBER 1423 N. LUZERNE AVE.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-13-17	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Operator				Steel Co.		Charow, S.C.	
13. FATHER'S NAME CAPLOP				14. MOTHER'S MAIDEN NAME ALICE LISBY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-05-2230		17. INFORMANT Mrs. Hattie Harrington 1423 Luzerne Ave	
18. 44 1.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BY SAW GUINATION (B) RUPTURE OF AORTIC ANEURYSM DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension of long standing		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initiate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from Dec 1 19 71 to Dec 7 2:00 PM 19 71 that (1) (we) last saw the deceased alive on Dec 7 2 PM 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael O'Keefe M.D.				23B. DATE SIGNED Dec-7 1971			
23C. PHYSICIAN'S NAME (Type) Michael O'Keefe M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR John E. [unclear]		25C. FUNERAL DIRECTOR Randolph J. Follick 2431 E. Oliver St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. K-532		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11440	
1. NAME OF DECEASED (Type or Print) Rose Myrtle Knotts			2. DATE AND HOUR OF DEATH 12/9/71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4443 Pen Lucy Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2864		
5. SEX female			6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12/5/1883			9. AGE (In years last birthday) 88		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper -retired			10B. KIND OF BUSINESS OR INDUSTRY B & O R R		11. BIRTHPLACE (State or foreign country) Grafton, W. Virginia
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Late Robert Thomas Knotts		
14. MOTHER'S MAIDEN NAME Late Mathilde Lucas			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 705-03-8931			17. INFORMANT Mrs. Grow, 4443 Pen Lucy Road, Balto, Md		
18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Anteriosclerotic Heart at least 5 yrs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cardio-Vascular 10 years			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DISEASE (B) DISEASE (C) DISEASE		
19A. DATE OF OPERATION 12/12/71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from September 1970 to December 9 1971 , that (I) (we) last saw the deceased alive on December 8 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Melvin N. Borden M.D.			23B. DATE SIGNED 12/9/71		
23C. PHYSICIAN'S NAME (Type) Dr. Melvin Borden			23D. ADDRESS 5000 Baltimore National Pike		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/71		24C. NAME of CEMETERY or CREMATORY Bluemont Cemetery	
24D. LOCATION (City, town, or county) Grafton, W. Virginia		24E. DATE REC'D BY HEALTH DEPT. DEC 10 1971		24F. NAME of REGISTRAR Robert E. Jansen, M.D.	
24G. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue Balto. Md		24H. ADDRESS 21228		24I. DATE REC'D BY HEALTH DEPT. DEC 10 1971	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11441	
H-100 71 11441 BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Katherine E. Hupp			2. DATE AND HOUR OF DEATH 12/7/71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 GENERAL GERMAN AGED HOME 22 S. ATHOL AVENUE			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY 2864 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 22 S. Athol Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1882	9. AGE (in years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Hungry		12. CITIZEN OF WHAT COUNTRY? Hungry
13. FATHER'S NAME Peter Demuth			14. MOTHER'S MAIDEN NAME Katherine Garwatz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 578-12-4589D		17. INFORMANT ADDRESS General German Aged Home 22 S. Athol Ave. 21229
18. 412.3 & 151.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Respiratory Failure (B) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C) chronic failure Carcinoma of stomach		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1970 to 12-7-1971 , that (I) (we) last saw the deceased alive on 12-7-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Bryson M.D.				23B. DATE SIGNED 7 Dec 71	
23C. PHYSICIAN'S NAME (Type) William J. Bryson, M. D.				23D. ADDRESS 4605 Edmondson Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/71		24C. NAME OF CEMETERY or CREMATORY Western	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Avenue 21228	

9/1/66 Adm.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

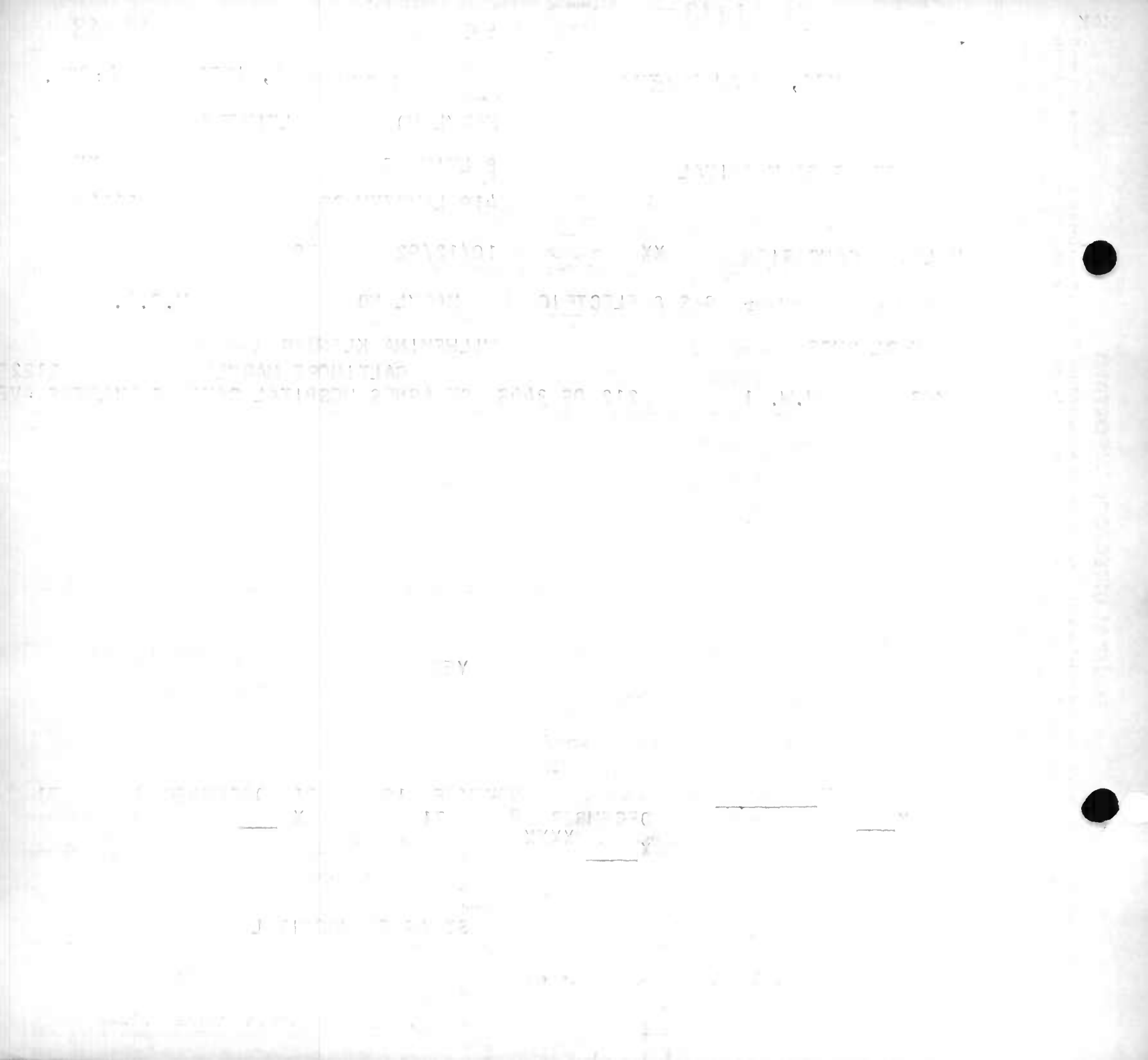
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11442	
<div style="font-size: 2em; font-weight: bold;">E-430 71 11442</div>				<div style="font-size: 2em; font-weight: bold;">71 11442</div>	
BIRTH NO. 68-06417				1. NAME OF DECEASED (Type or Print) Jarrett Elliott	
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 12-9-71 3:30 AM.	
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
				A. STATE Md B. COUNTY Baltimore	
C. CITY OR TOWN Ellicott City				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 2533 Melba Rd Ellicott City, Md. 21043	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-68		9. AGE (In years last birthday) 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Richard William Elliott		
14. MOTHER'S MAIDEN NAME Patricia Ann Scharf			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Patricia Ann Scharf		
18. ADDRESS 2533 Melba Rd. 21043			19. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest Prob aspiration or increased intracranial pressure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/1 to 12/9 19 71 and that (I) (we) last saw the deceased alive on 12/9 19 71 and that (in my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Y H Lim				23B. DATE SIGNED 12/9/71	
23C. PHYSICIAN'S NAME (Type) Young Hsi Lim M.D.				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/71		24C. NAME OF CEMETERY OR CREMATORY Crestlawn	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971			
25B. NAME OF REGISTRAR Robert G. Faber, M.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228			

MAK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-200		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11443	
1. NAME OF DECEASED (Type or Print) RUSS, WILLIAM OTTO				2. DATE AND HOUR OF DEATH DECEMBER 8, 1971 4:00P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 419 LAMBETH RD 21228			
5. SEX MALE	6. RACE CAUCASION	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/92	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Supervisor		10B. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KARL RUSS (deceased)				14. MOTHER'S MAIDEN NAME WILHEMINA KLENDER (deceased)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES W.W. 1		16. SOCIAL SECURITY NO. 212 05 3445		17. INFORMANT BALTIMORE MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE			
18. 410,91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute M. infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary edema cholecystitis - cholelithiasis				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 12/11/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Involuntarily medical examined		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 19 19 71 to DECEMBER 8 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 8 19 71 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) XXXX view the body after death.							
23A. SIGNATURE N. Stratigakos DEGREE						23B. DATE SIGNED 12.9.71.	
23C. PHYSICIAN'S NAME (Type) Nicholas Stratigakos DEGREE		23D. ADDRESS ST AGNES HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/71		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue		ADDRESS 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

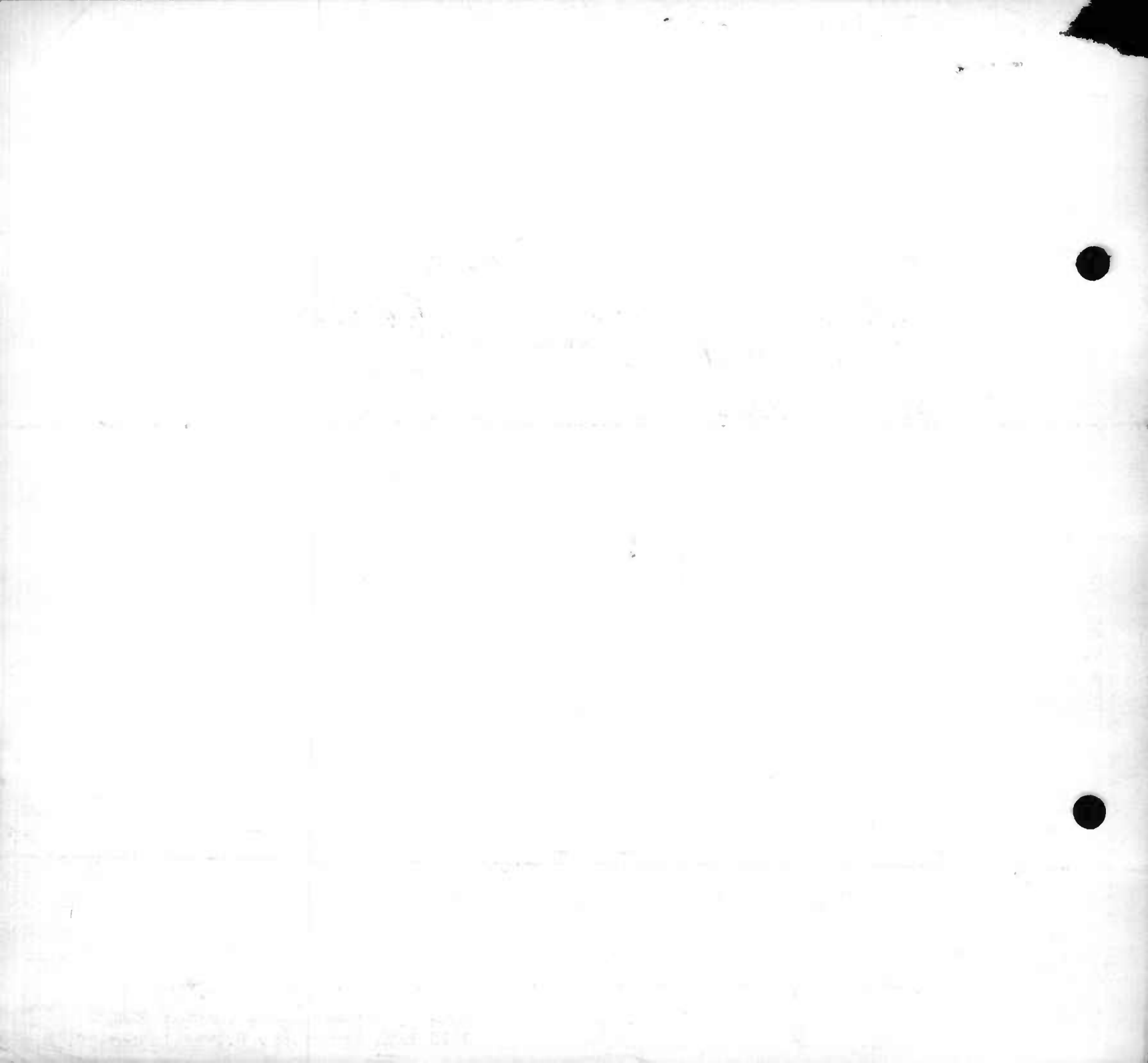
8-365 71 11444		BALTIMORE CITY HEALTH DEPARTMENT		71 11444	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
EMMA REGINA STROHMINGER		12/8/71		3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
00 4724 DUNKIRK AVE.		MARYLAND		2854	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		4724 DUNKIRK AVE.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months; Days
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10/17/1910	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		Home		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
CHARLES FREIBERG		EMMA -		U.S.A.	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Mrs. Emma Marion Humphries - 4724 Dunkirk Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Coronary artery occlusion		Sudden	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Atherosclerotic Cardio Vascular disease			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Diabetes Mellitus -			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4-12-1971 to 12-8-1971 that (I) (we) last saw the deceased alive on 11-22-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. cleared & medical examiner					
23A. SIGNATURE		23B. DATE SIGNED			
H. L. KNIPP, M.D.		12-10-71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
H. L. KNIPP, M.D.		4116 Edmondson Ave Balt Md 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		HOLY REDEEMER Cem.		BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 10 1971		J. E. Miller, Jr.		2334 Jefferson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

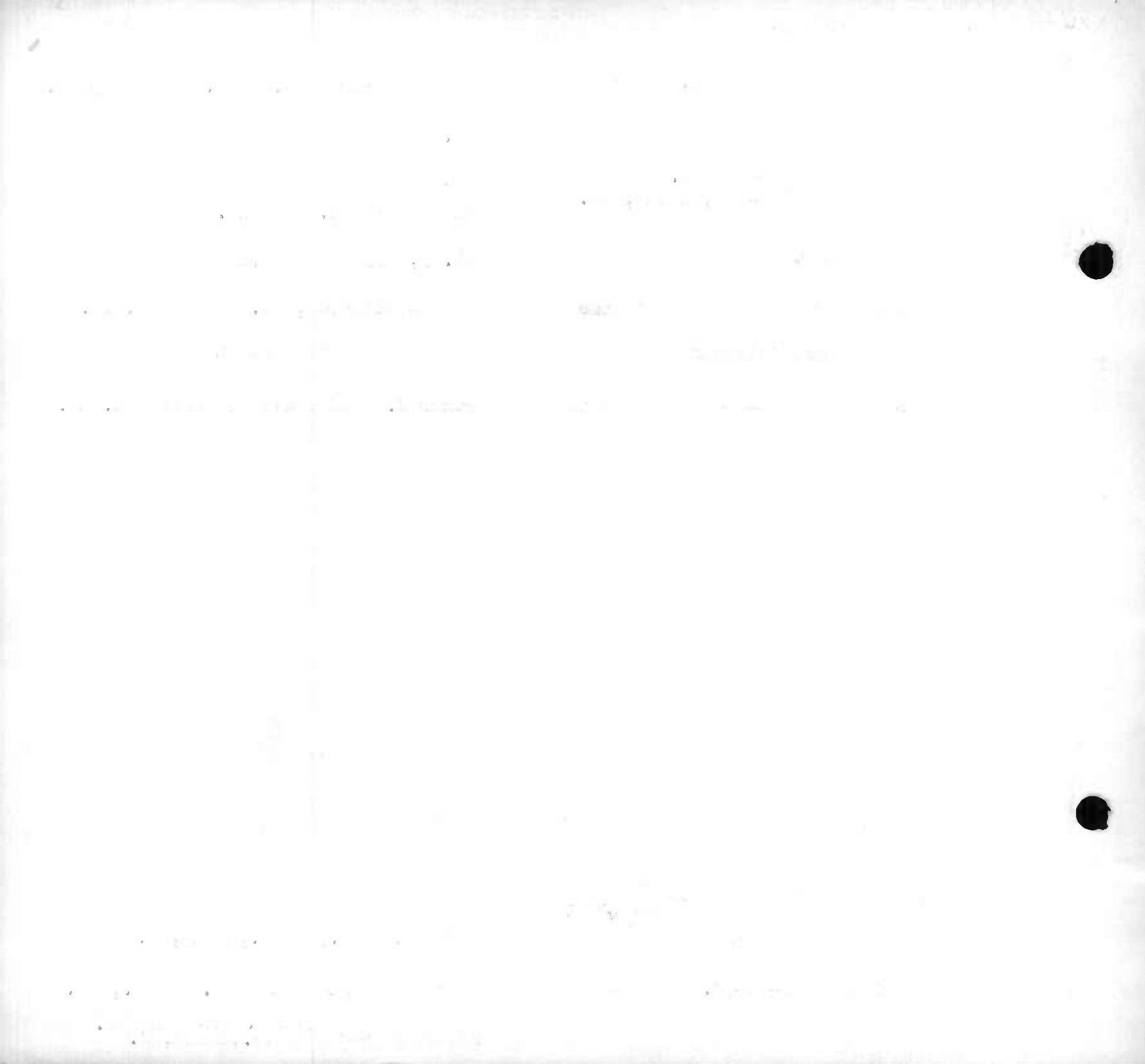
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11445	
71 11445				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSE SEABORNE		2. DATE AND HOUR OF DEATH 12/4/71 5:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALD.		C. CITY OR TOWN BALD.	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 616 RESERVOIR ST	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/81	9. AGE (In years last birthday) 90	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Seaborne		14. MOTHER'S MAIDEN NAME Caroline	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 578-49-0406		17. INFORMANT Lucretia Blackstone	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subdural Hematoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Subdural Hematoma			
(B) pulmonary arteriole thrombosis		DUE TO, OR AS A CONSEQUENCE OF:			
(C) and right subdural hematoma		DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 616 Reservoir St.	
21D. TIME OF INJURY (Approx.) 4:00 PM 11-14-71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FALL DOWN STAIRS	
22. I certify that (I) (this hospital) attended the deceased from 11/19/71 19__ to 12/4/71 19__ that (I) (we) last saw the deceased alive on 12/3/71 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Phillip E. Middleton M.D.		23B. DATE SIGNED 12/4/71		23C. PHYSICIAN'S NAME (Type) PHILLIP E. MIDDLETON MD	
23D. ADDRESS MARYLAND GENERAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-71	
24C. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Suitland, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John T. Rhines		25D. ADDRESS Company Funeral Home 3015 12th Street, N.E., Washington, D.C.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 11446				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11446	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ROSA A. WULF				December 8, 1971. 5:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		8. COUNTY	
00 411 Bonsal St.		Baltimore, 21224, Md.		Md.		2605	
5. SEX				6. DATE OF BIRTH		9. AGE (In years last birthday)	
Female				Oct. 15, 1895		76	
7. RACE				10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
White				At Home		Baltimore, Md.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME	
House Work				U.S.A.		James Callahan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				NONE		Arthur C. Wulf : 411 S. Bonsal St. #24.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				malnutrition of colon			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Dec. 1961 to 12/8 1971 that (I) last saw the deceased alive on 12/6 1971 and that (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Joseph R. Liberto M.D.				12/19/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOSEPH R. LIBERTO				3501 Bank St., Balto., 21224, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) 15otel	
Burial		12-11-71.		Baltimore Cemetery		East North Ave. Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 10 1971		Robert E. Barber, R.D.		Charles S. Jester		901 S. Conkling St. Balto., 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

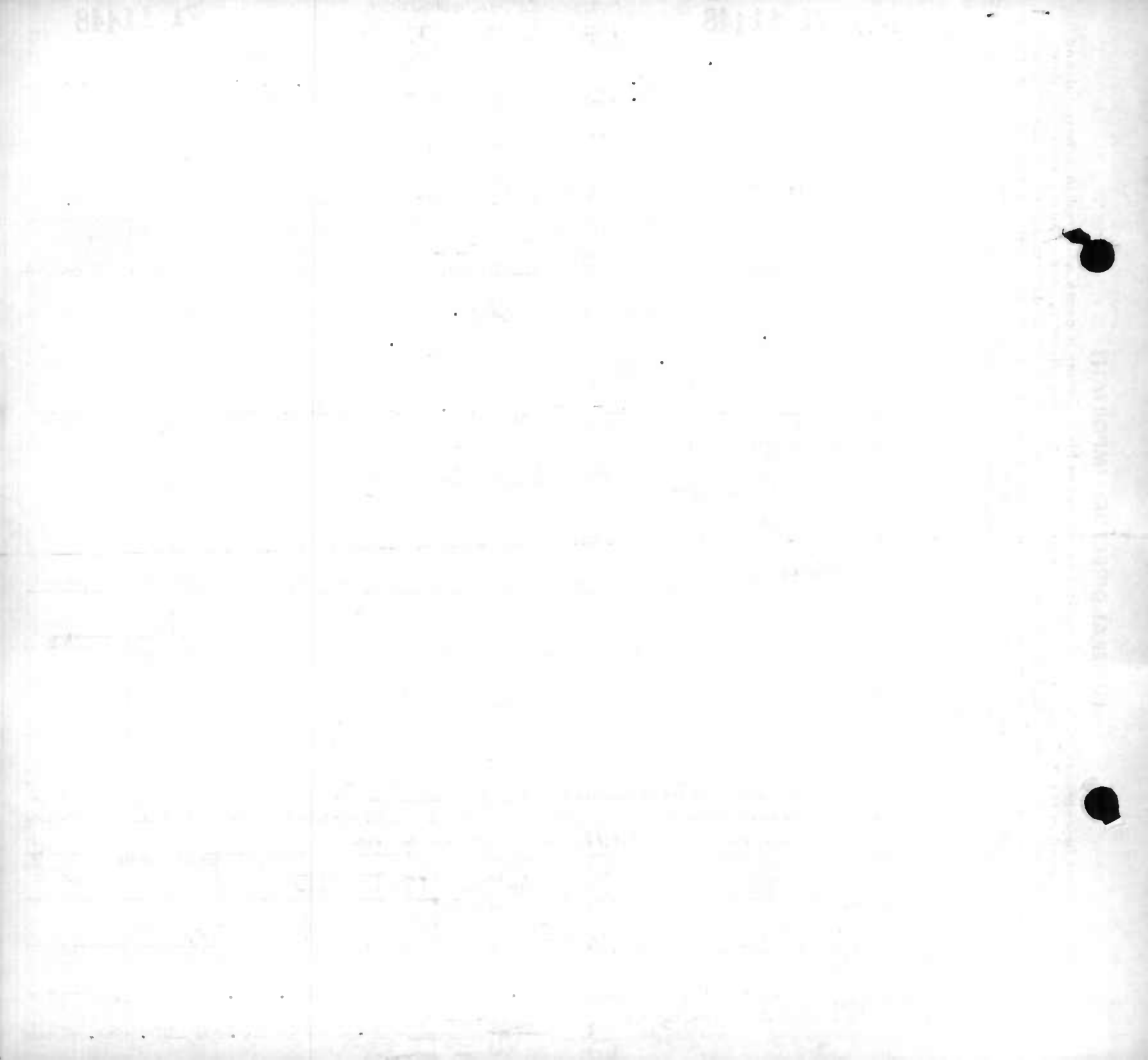
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 11447				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 11447	
1. NAME OF DECEASED (Type or Print) <u>Grier Marshall G.</u> (MARSHALL G. GRIER)				2. DATE AND HOUR OF DEATH <u>Dec. 8, 1971</u> <u>2:15 A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Balto., Md.</u> B. COUNTY <u>2642</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>4229 Seidel Avenue, #</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06-16-07</u>		9. AGE (In years last birthday) <u>64</u>		11. Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <u>American</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>UNION TRUST CO.</u>			11. BIRTHPLACE (State or foreign country) <u>STREET, HARBOR CO., Maryland</u>			
13. FATHER'S NAME <u>ELMER GRIER</u>				14. MOTHER'S MAIDEN NAME <u>JOSEPHINE BUTLER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-03-2462</u>		17. INFORMANT <u>ISABELA GRIER</u> ADDRESS <u>4229 SEIDEL AVE. MD.</u>			
18. <u>430191</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Sudden cardiac (Myocardial) infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>A-V block</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>Dec 7, 1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 7, 1971</u> 19 <u>71</u> to <u>Dec 8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Dec 8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>[Signature]</u>				DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Dec 8, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>FULLO BERTORINI</u>				23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-11-71</u>		24C. NAME of CEMETERY or CREMATORY <u>SHERWOOD E.P. CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>COCKEYSVILLE, BALTO. CO., MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD.</u>		25C. FUNERAL DIRECTOR <u>Charles S. Seiler</u>		ADDRESS <u>824 EASTERN AVE. BALTO., 21224, MD.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. <u>71 11448</u>	
BIRTH NO. <u>L-520 71 11448</u>				1. NAME OF DECEASED (Type or Print) <u>Richard Long Sr.</u>		2. DATE AND HOUR OF DEATH <u>Dec. 9, 1971</u> <u>12:45 AM.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>905</u>		C. CITY OR TOWN <u>Balto</u>	
5. SEX <u>M</u>				6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-2-44</u>				9. AGE (In years last birthday) <u>27</u>		10. Under 1 Yr. Months: <u> </u> Days: <u> </u> 11. Under 24 Hrs. Hours: <u> </u> Min. <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Grue Tailoring</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>S. Walter Long Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>D. Myrtle Knell</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>219-42-0810</u>				17. INFORMANT <u>Mrs. Linda Long same</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Chronic Coronary</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u> </u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u> </u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
19A. DATE OF OPERATION <u> </u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20A. AUTOPSY? (Yes or No) <u> </u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u> </u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) <u> </u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u> </u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u> </u>		22. I certify that (1) (this hospital) attended the deceased from <u>11-17</u> 19 <u>71</u> to <u>12-9</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>12-9</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Cladius Kliment</u>				23B. DATE SIGNED <u> </u>		23C. PHYSICIAN'S NAME (Type) <u>CLadius Kliment</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12/11/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Sabey, M.D.</u>				25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11449	
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		ARCHER, JR. JESSE HOSKINS		2. DATE AND HOUR OF DEATH DECEMBER 9, 1971 6:45A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND CITY BALTIMORE		5. ZIP CODE 21230	
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07 18 07	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PUMP OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY FIRE DEPT.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESSE H. ARCHER				14. MOTHER'S MAIDEN NAME CATHERINE (FROST)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212107702		17. INFORMANT WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 23 1971 to DECEMBER 9 1971 that (X) (we) last saw the deceased alive on DECEMBER 9 1971 and that in (Xy) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) (X) view the body after death.							
23A. SIGNATURE Leroy Buckler M.D.				23B. DATE SIGNED 12/9/71		23C. PHYSICIAN'S NAME (Type) LEROY BUCKLER, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/71		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR McCully Funeral Homes 130 E. Fort Avenue			

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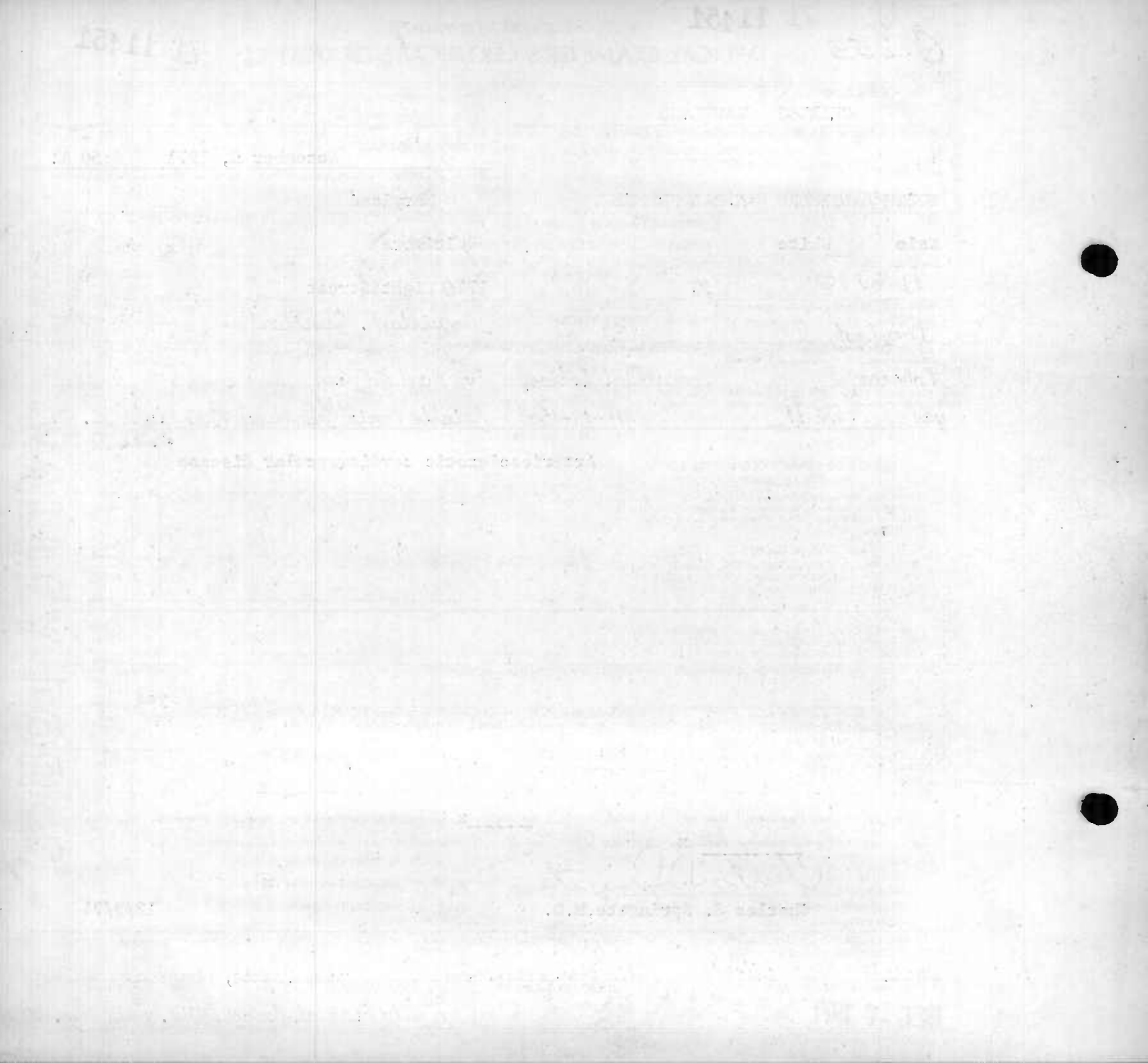
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-642		71 11450		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11450	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Gustave Borleske</i>			
2. DATE AND HOUR OF DEATH <i>12-5-71</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>90 Gould Convalescent Home</i>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>BALTO</i>				5. SEX <i>Male</i> 6. RACE <i>White</i>			
C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <i>529 St. Patrick Road</i>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>9-12-1880</i>				9. AGE (In years last birthday) <i>91</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Far, Worker (retired)</i>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Germany</i>				12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>			
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>217-16-8160</i>			
17. INFORMANT <i>Mr. William Borleske - 529 St. Patrick Rd.</i>				ADDRESS			
18. <i>712-34-199-1</i>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Heart Disease</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>General Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) <i>Gastric Ulcer, post-malignant, Chronic, severe</i>			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/29/71</i> to <i>12/1/71</i> that (I) (we) last saw the deceased alive on <i>12/3/71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>Arthur B. Brandy</i>							
23B. DATE SIGNED <i>12/7/71</i>							
23C. PHYSICIAN'S NAME (Type) <i>Robert E. Fisher, M.D.</i>							
23D. ADDRESS <i>John C. Miller Inc-6415 Belair Rd.-21206</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>							
24B. DATE <i>12-9-71</i>							
24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>							
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>							
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 10 1971</i>							
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>							
25C. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Rd.-21206</i>							
ADDRESS							



1. NAME OF DECEASED (Type or Print) CHARLES GRANTLAND		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 SOUTH BALTIMORE GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year December 9, 1971 Hour 6:50 A.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 13 Nov 1921		10. AGE (In years lost birthday) 50	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Melville F. Grantland		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2303	
15. MOTHER'S MAIDEN NAME Eva Mead McCarty		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes	
17. SOCIAL SECURITY NO. 214-14-1588		18. INFORMANT Wife Estelle Marie Grantland	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/9/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/71	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR McCully Funeral Homes		ADDRESS 130 E. Fort Ave. 2123	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-14071 11452		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11452	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Minnie Shipley		2. DATE AND HOUR OF DEATH December 7, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		M. 1902	
FULL NAME OF HOSPITAL OR INSTITUTION 13 South Stricker Street		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 13 South Stricker Street 21223	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1895	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Kuhl		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT James G. Phelps 13 So. Stricker St. 21223	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart arrest. D.O.A. - myocardial infarction. (B) DUE TO, OR AS A CONSEQUENCE OF: Angina Pectoris - A.S. (C) heart disease.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1968 to Dec. 7, 1971, that (I) (we) last saw the deceased alive on Dec. 7, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudars		23B. DATE SIGNED 12.8.71		23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDARS	
23D. ADDRESS 1101 Maiden Choice La. Baltimore		23E. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/71		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore City, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker		24H. ADDRESS Streets 21223			

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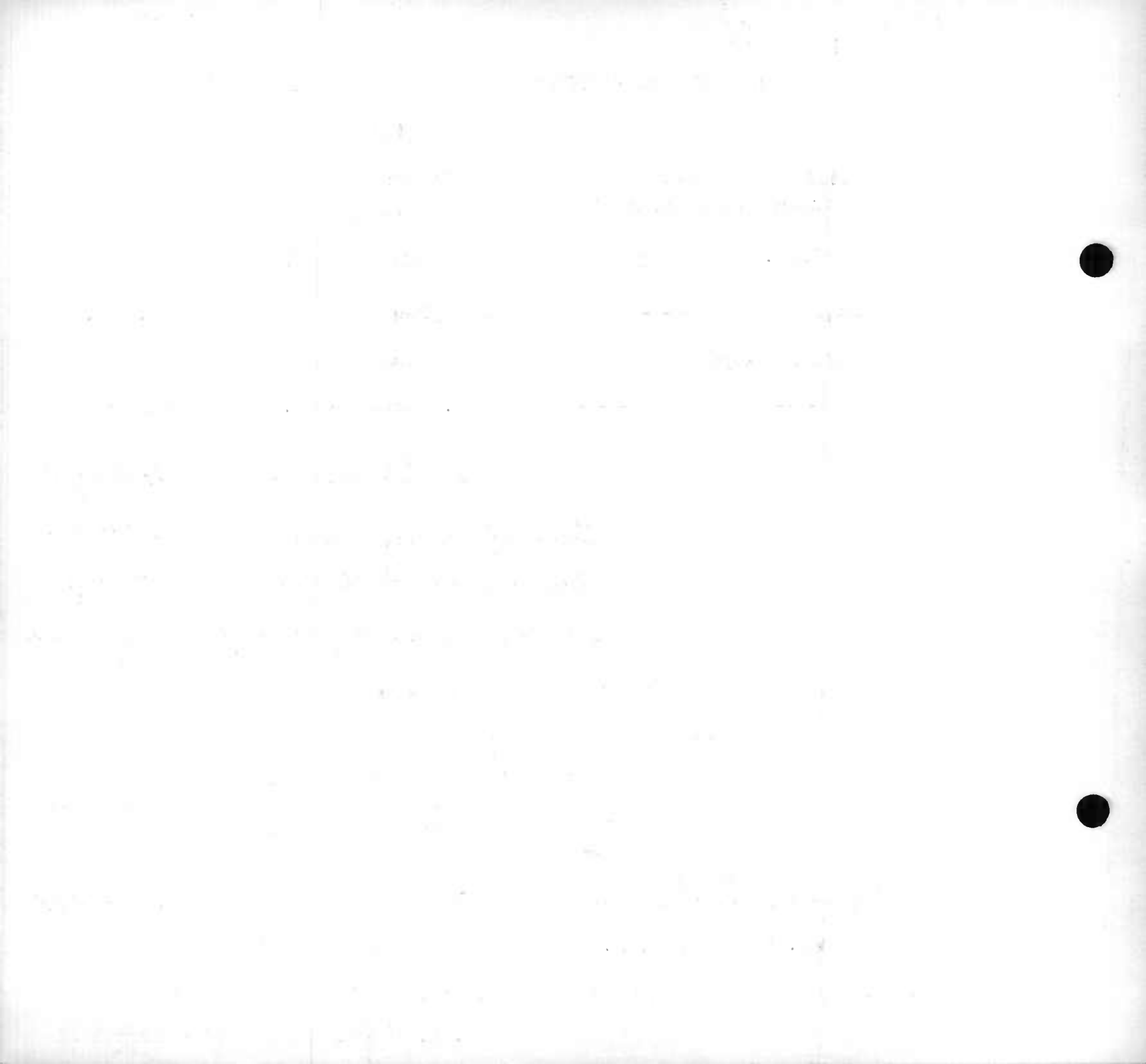
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-360		71 11453		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11453	
1. NAME OF DECEASED (Type or Print) Hattie Helene RUTTER				2. DATE AND HOUR OF DEATH December 7, 1971			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3303 Menlo Drive Baltimore, Maryland 21215				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2740 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3303 Menlo Drive			
5. SEX Female	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1884	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Thomas Lloyd				14. MOTHER'S MAIDEN NAME Sophie Hahn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. - - -		17. INFORMANT ADDRESS Mrs. Bernadette R. Norris 3303 Menlo Drive		
18. 440.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Debridement ulcer right hip							
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) none		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none			
21D. TIME OF INJURY (Approx.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> While At Home <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? none			
22. I certify that (I) (this hospital) attended the deceased from January 1 19 71 to December 7 19 71 that (I) (we) last saw the deceased alive on December 7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (we) (did not) view the body after death.							
23A. SIGNATURE Milton E. Lowman				23B. DATE SIGNED Dec 8, 1971		23C. PHYSICIAN'S NAME (Type) Milton E. Lowman, M. D.	
23D. ADDRESS 1401 Reisterstown Road							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9 DEC 71		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR John E. Lowman, Jr.		25C. FUNERAL DIRECTOR J. E. Lowell Lemmon		25D. ADDRESS 6500 York Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-252-71 11454		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 11454	
1. NAME OF DECEASED (Type or Print) Mr. Stanley Kaczinski			2. DATE AND HOUR OF DEATH NOV. 29 1971 8th A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Edgewood Nursing Home FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6000 Bellona Ave. Baltimore, Md. 21212			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY 103		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 609 S. Montford Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-8-1896	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER RET.		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL	11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ADAM			14. MOTHER'S MAIDEN NAME ANNA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 215-07-2414	17. INFORMANT MRS. LAURA KACZINSKI ADDRESS 609 S. MONTFORD AVE		
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Hypertensive Cardio ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. VASCULAR DISC. Cerebral Arterio Sclerosis - (GENERAL) Arteriosclerosis -			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/18/1971 to 11/29/1971 that (I) (we) last saw the deceased alive on 11/29/1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anthony F. Carozza			23B. DATE SIGNED 11-29-1971		23C. PHYSICIAN'S NAME (Type) ANTHONY F. CAROZZA
23D. ADDRESS 5217 YORK RD BALTO MD 21212			24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 12/3/71		24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR RAYMOND L. KACZAROWSKI ADDRESS 2525 FLEET ST.	

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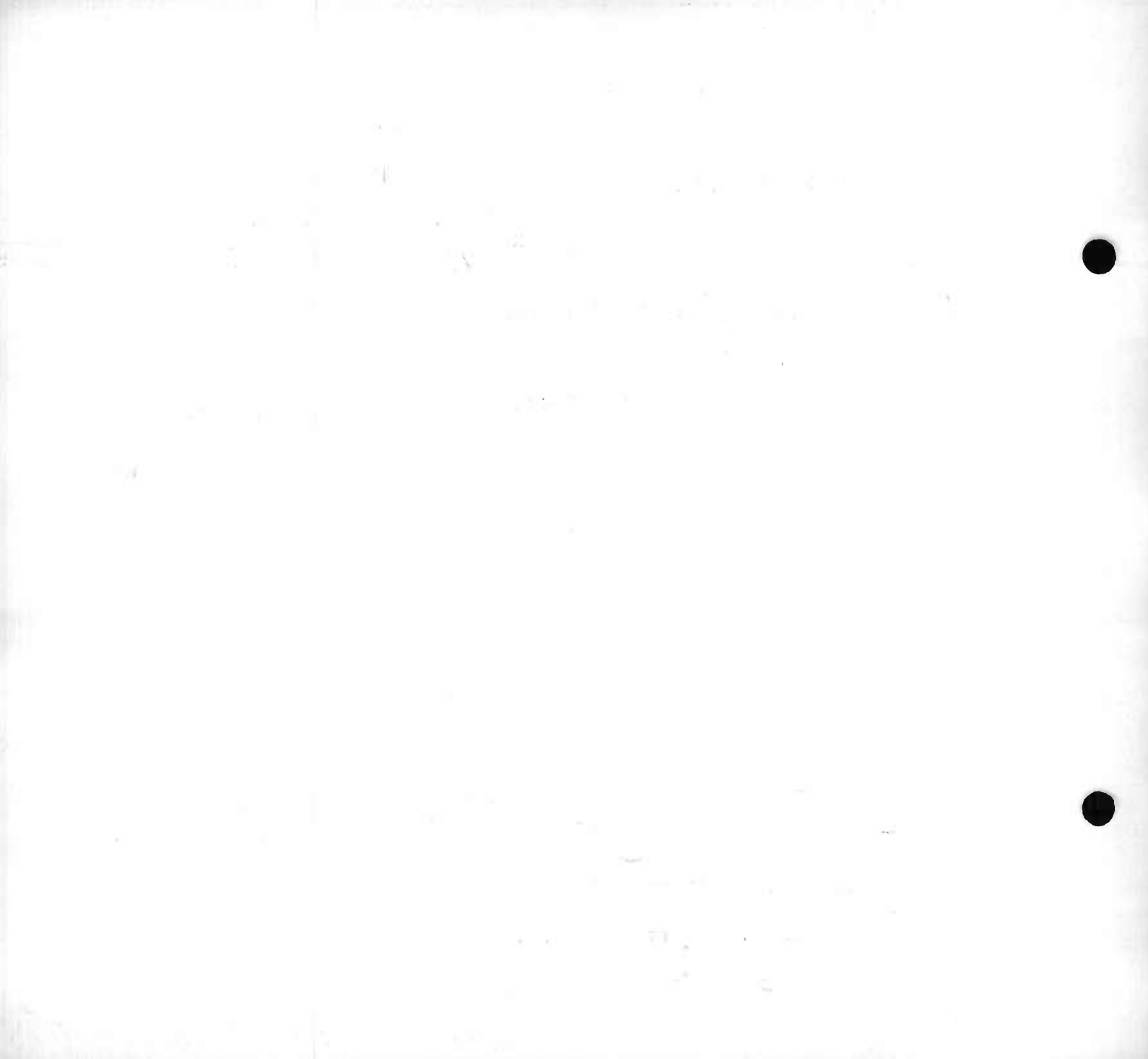
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11455	
<div style="display: flex; justify-content: space-between;"> S-432 71 11455 </div>					
1. NAME OF DECEASED (Type or Print) SCHULTZ, ROBERT			2. DATE AND HOUR OF DEATH 11-30-71 3:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 105 105		
5. SEX MALE			6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 04/14/33			9. AGE (In years last birthday) 38		If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN			10B. KIND OF BUSINESS OR INDUSTRY AMERICAN STANDARD		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME SCHULTZ, ALEXANDER		
14. MOTHER'S MAIDEN NAME NIEDZIELSKI, STELLA			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 214 26 4911			17. INFORMANT MRS. STELLA SCHULTZ		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE HEPATIC COMA, RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: SEPSIS (B) CIRRHOSIS OF LIVER, CA OF TONGUE DUE TO, OR AS A CONSEQUENCE OF: 9-1-71 (C) CHRONIC ALCOHOLISM			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-22-71 MANY YEARS		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-4 1971 to 11-30 1971 that (I) (we) last saw the deceased alive on 11-30 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John A. Nesbitt III MD			23B. DATE SIGNED 11-30-71		23C. PHYSICIAN'S NAME (Type) JOHN A. NESBITT III M.D.
23D. ADDRESS JOHNS HOPKINS HOSPITAL			24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 12/4/71			24C. NAME OF CEMETERY or CREMATORY Holy Rosary CEMETERY		
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.			25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		
25B. NAME OF REGISTRAR Robert E. Farber, M.D.			25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		
25D. ADDRESS 2525 FLORES					



L-350 71 11456		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		71 11456	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)		WILLIAM LOUDEN		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		00 249 S. Broadway 2nd floor		3. DATE PRONOUNCED DEAD		Month Day Year Hour 11 27 1971 11:30p M.	
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 604	
9. DATE OF BIRTH 12/31/1924		10. AGE (In years last birthday) 47		11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID LOUDEN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT MRS. Emma LOUDEN		19. CAUSE OF DEATH Fatty metamorphosis of liver		20. DATE OF OPERATION 2	
21. AUTOPSY? (Yes or No) HEAD ONLY		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		24. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR?		27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. DATE 12/6/1971	
29. NAME OF CEMETERY or CREMATORY OAKLAWN CEMETERY		30. LOCATION (City, town, or county) (State) BALTIMORE MD.		31. DATE REC'D BY HEALTH DEPT. DEC 10 1971		32. NAME OF REGISTRAR Robert E. Farber, M.D.	
33. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		34. ADDRESS 2525 FLEET ST.		35. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		36. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

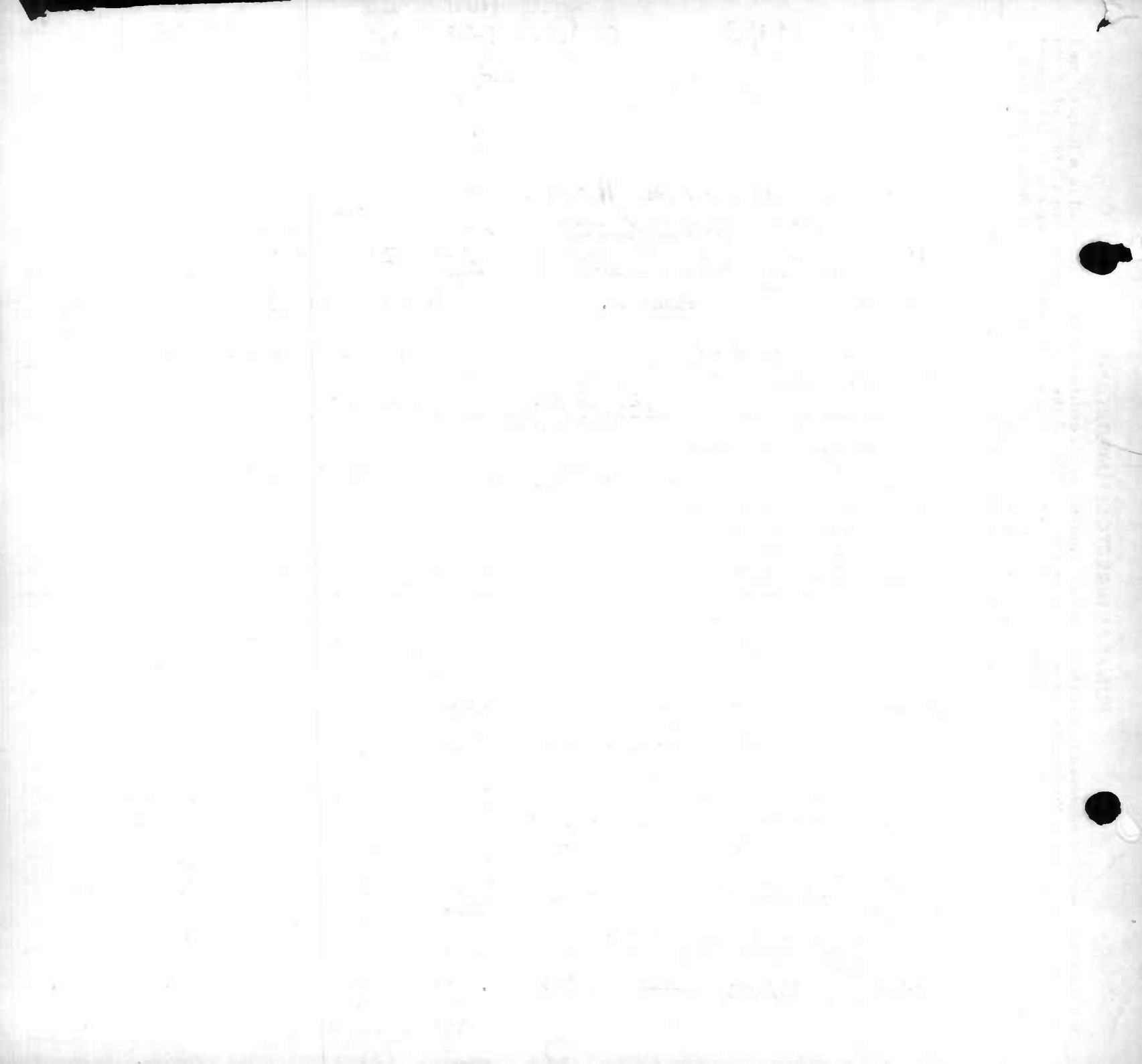
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11457	
M-254 11457					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY Clara McNulty		2. DATE AND HOUR OF DEATH 12-5-71 5:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 91 Keswick			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 901		
FULL NAME OF HOSPITAL OR INSTITUTION 91 Keswick			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 3965 Wilsby Avenue		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-1896	9. AGE (In years, last birthday) 75	10. Under 1 Yr. Months 11. Under 24 Hrs. Days 12. Under 24 Hrs. Hours 13. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottler at National Distillers		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
13. FATHER'S NAME Thomas F. McNulty			14. MOTHER'S MAIDEN NAME Clara Gertrude Magarity		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-4306		17. INFORMANT Keswick Records	
18. 410-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1. This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY THROMBOSIS (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr many yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Residual hemiplegia occ to left side since 1967					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/21 19 70 to 12/5 19 71 that (I) (we) last saw the deceased alive on 12/5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold P. Biehl			23B. DATE SIGNED 12-6-71		23C. PHYSICIAN'S NAME (Type) Harold P. Biehl
23D. ADDRESS 301 St. Paul Place, Baltimore, Md. (office)			23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/9/71	24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Fred Rd Balto. Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Faber, Md.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home	
25D. ADDRESS 6500 York Rd					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

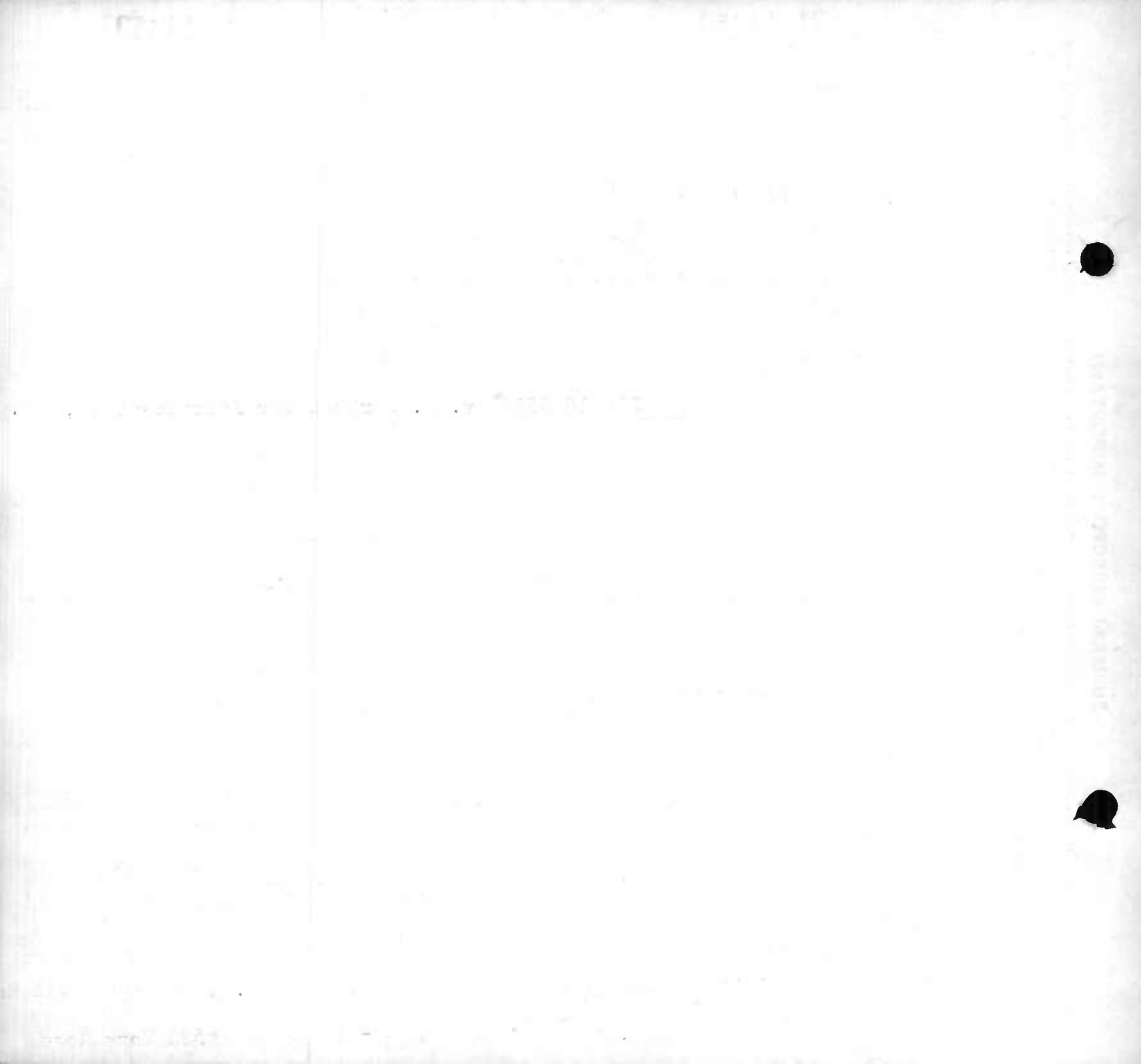
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71-11458	
BIRTH NO. K-52411 11458 KUNKEL		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Kunkel, Joseph A.		2. DATE AND HOUR OF DEATH 12-6-71 1245 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY MD 2711			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 14 Charlotte place					
5. SEX M	6. RACE Cav	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-21	9. AGE (In years last birthday) 50	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10B. KIND OF BUSINESS OR INDUSTRY Piano Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME J. Kunkel		14. MOTHER'S MAIDEN NAME DORA BECKER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215 18 5329		17. INFORMANT ADDRESS CHART	
18. 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE cardiac arrest			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CHF		6)	
		(C) Rheumatic heart disease		97	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 5 19 71 to Dec 6 19 71 that (I) (we) last saw the deceased alive on Dec 6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED Dec 6, 1971			
23C. PHYSICIAN'S NAME (Type) JULIO BERSORINI		23D. ADDRESS UNION MEMORIAL HOSP			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 12/9/71		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Gds	
24D. LOCATION (City, town, or county) (State) Padonia Rd Balto Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Talley, Jr.		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

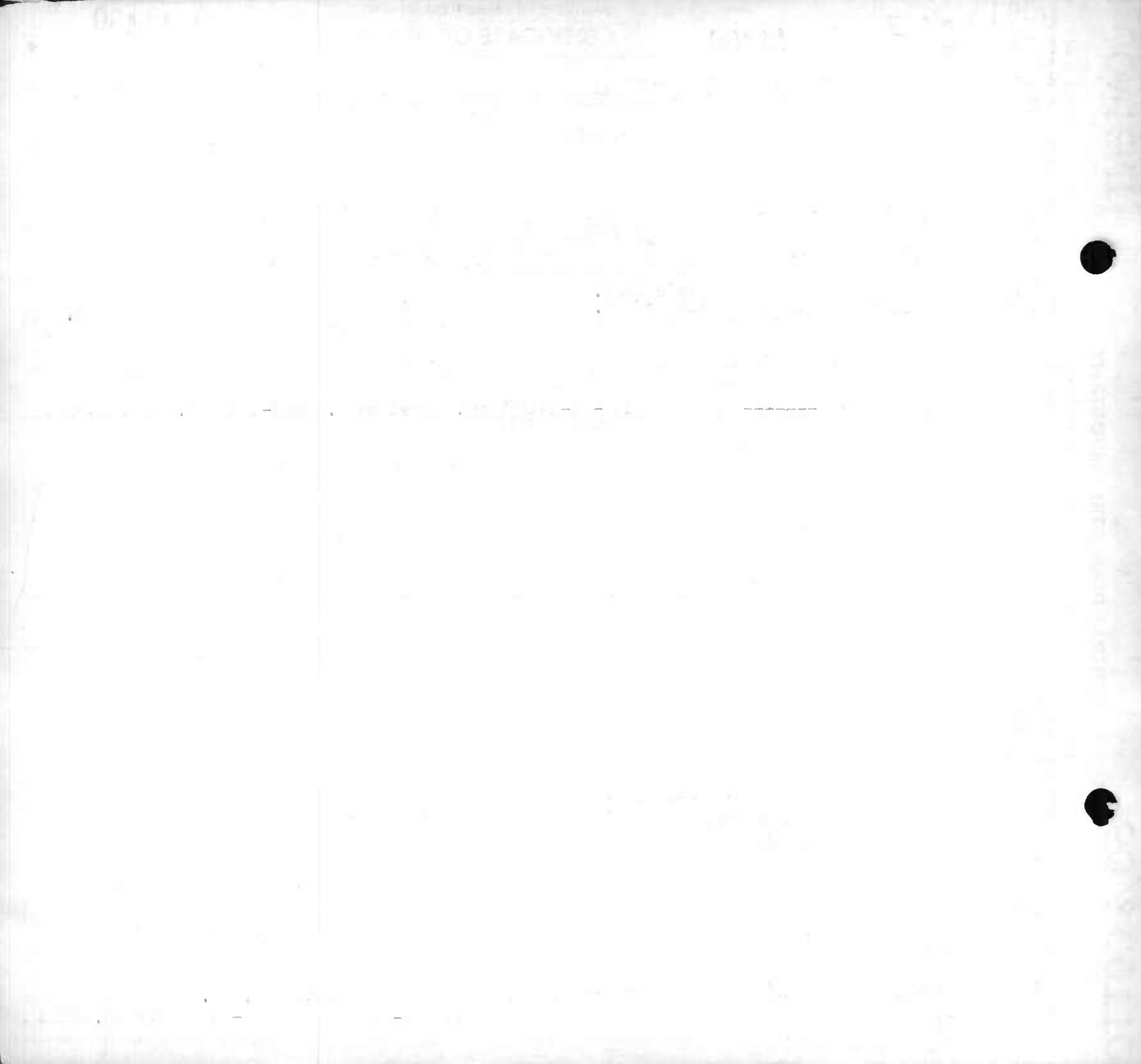
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11459	
<div style="display: flex; justify-content: space-between;"> H-400 71 11459 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Kall Edna		2. DATE AND HOUR OF DEATH 12-7-71 7⁴⁵ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			A. STATE Md B. COUNTY Balto		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 701 Concord Ave Balto 21218					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-24-05	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Louis Warkmeister		14. MOTHER'S MAIDEN NAME Ana Sterns		12. CITIZEN OF WHAT COUNTRY? American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 16 5526		17. INFORMANT ADDRESS Mr. C. Warkmeister Jarrettsville, Md.	
18. 0389 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bauche respiratory arrest		
			(B) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: Septicemic shock		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-03 19 71 to 12-07 19 71 that (I) (we) last saw the deceased alive on 12-07 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED Dec 7, 1971		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) JULIO BERTORIANI			23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/71		24C. NAME of CEMETERY or CREMATORY Lake View Cemetery	
24D. LOCATION Liberty Rd. & Oakland Mill Rd		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971			
25B. NAME OF REGISTRAR Robert E. Faber		25C. FUNERAL DIRECTOR ADDRESS MITCHELL WIEDEFELD 6500 York Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300 71 11460		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11460	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN J. BOYD		DEC. 5 71 9 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY	
44		UNION MEMORIAL HOSPITAL		MARYLAND	
				C. CITY OR TOWN	
				BALTIMORE	
				D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2817 ST. PAUL ST	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	02/18/09	62	ATTORNEY
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Roads Comm. State of Md.		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
ISRAEL BOYD		SADDIE HAGARTY		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		219-32-2410		Mrs. Carlita R. Boyd-2817 St. Paul Street	
18. 431.9 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) Cerebral Hemorrhage			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		(C) ARTERIO-SCLEROSIS			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/20/71 to 12/5/71 that (I) (we) lost saw the deceased alive on 12/5/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
[Signature]		12/5/71		CESAR VILLARON	
23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS	
33rd. and Calvert St.		Mitchell-Wiedefeld Home-6500 York Rd.		21212	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12/9/71		Baltimore Cemetery	
24D. LOCATION		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore, Md.		DEC 10 1971		Robert E. Farley, Jr.	



71 11461		BALTIMORE CITY HEALTH DEPARTMENT	
H-320		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO. 71 11461	
1. NAME OF DECEASED (Type or Print) LARRY HODGE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year December 8, 1971 Hour 9:20 P.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1608	
7. RACE Negro		C. CITY OR TOWN Baltimore	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 10-1-38		10. AGE (In years last birthday) 33 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chester Hodge		14. STREET AND NUMBER 817 Woodington Road	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Monarch Rubber Co.		15. MOTHER'S MAIDEN NAME Catherine Blackwell	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 219269863	
18. INFORMANT Waldalene Hodge		ADDRESS 817 Woodington Rd.	
19. E 965 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2938 Westwood Road		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12-8-71 9:00 P.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/9/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson Funeral Home 1348 Calhoun St.	

1811

1811



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420 71 11462		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11462	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BLAKEL. HENRY		2. DATE AND HOUR OF DEATH 12/9/1971 at 1:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 1601			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland 730 Ashburton Street.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3313 Poplar St.			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/04	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO.		17. INFORMANT Annie Belle Ross 947 Chase Street	
18. 486 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia Rt Lung DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Chronic Brain Syndrome			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/30/1971 to 12/9/1971 that (I) (we) last saw the deceased alive on 12/9/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Suresh Penkar		23B. DATE SIGNED 12/9/1971			
23C. PHYSICIAN'S NAME (Type) SURESH PENKAR		23D. ADDRESS Lutheran Hospital 730 Ashburton, Baltimore Md 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR E. Bailey, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		25D. ADDRESS Kelson F.H. 1348 Calhoun Street			

7/1/70

1021 Carlton St.

B-620 71 11463
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 11463

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) HELEN BROOKS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year December 8, 1971 9:10 A. M.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1608	
7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 6-18-10	10. AGE (In years last birthday) 61	E. STREET AND NUMBER 635 N. Augusta Street AVE	
11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Offius C. Alexander	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Elizabeth Leanna Marshall	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 212566212	
18. INFORMANT Naomi Foster		ADDRESS 1376 Calhoun St.	
19. 412.4		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-71	
24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun St.	

Serial 17

Serial 17

1944

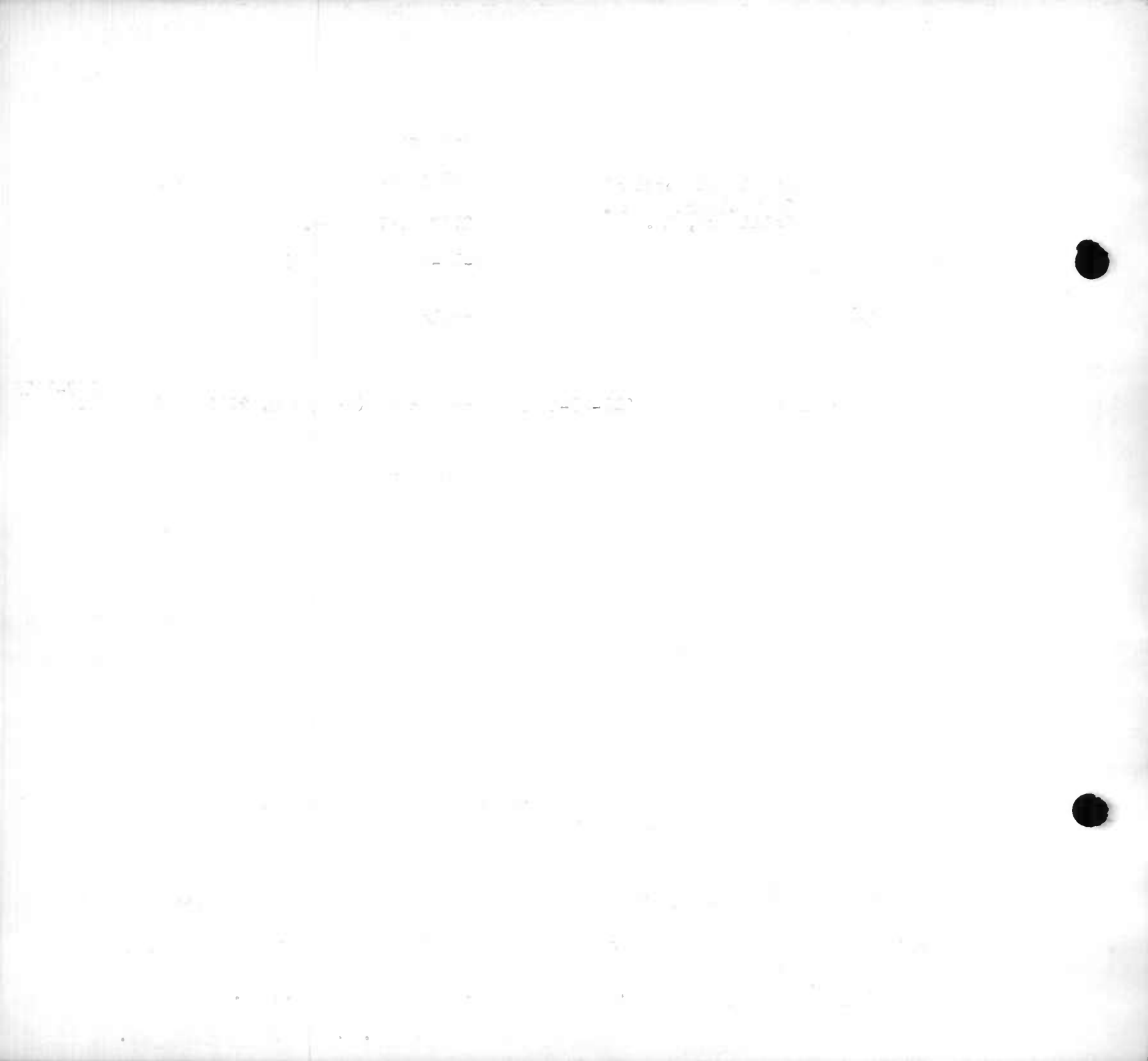
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11464	
C-12071 11464		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) William Cephas		December 6, 1971 1 32 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1538	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 2600 Liberty Hgts. Baltimore, Md.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		9. AGE (In years last birthday) 83	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Wm. Cephas		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 217-07-1045	
17. INFORMANT Mary Scott (daughter)		ADDRESS 367-7425 2703 Roslyn Ave.	
18. 486X I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 23, 1971 to December 6, 1971 that (I) (we) last saw the deceased alive on December 6, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Lewis B. Boone, M.D.		23B. DATE SIGNED Dec. 6, 1971	
23C. PHYSICIAN'S NAME (Type) Lewis B. Boone M.D.		23D. ADDRESS Provident Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		12-11-71	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11465	
BIRTH NO. 1-362 71 11465		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Patterson, Edith			2. DATE AND HOUR OF DEATH December 6, 1971 8:00 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 2600 Liberty Hgts. Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore E. STREET AND NUMBER 557 Laurens St. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 5-18-95	
13. FATHER'S NAME Nickademus Snowden		14. MOTHER'S MAIDEN NAME Sarah		9. AGE (In years last birthday) 76	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-20-3975		11. BIRTHPLACE (State or foreign country) Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 197.8 I CAUSE OF DEATH (Probable) metastatic (Liver) CARCINOMA ASHD & coronary insufficiency		12. CITIZEN OF WHAT COUNTRY? USA		17. INFORMANT Leonard Patterson-son 4005 Duval 523-6145 Carrie Schonhoff (Daughter) 3426 Auchentoroly	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-8-19 71 to 12-6-19 71 that (I) (we) last saw the deceased alive on 12-6-19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elizah Saunders			23B. DATE SIGNED 12/9/71		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12-10-71		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1971			25B. NAME OF REGISTRAR Robert E. Bailey, Md.		25C. FUNERAL DIRECTOR Kelson F.H. 1348 Calhoun St.

1-10-55

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1-10-55

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-600 71 11466		BALTIMORE CITY HEALTH DEPARTMENT		71 11466	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>James E. Gurry</i>		2. DATE AND HOUR OF DEATH <i>12-8-71 9 P.</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 734 E. Fort Avenue</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2402</i>			
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>734 E. Fort Avenue</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-18-08</i>	9. AGE (In years last birthday) <i>63</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Log Skidman</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Martin Gurry</i>		14. MOTHER'S MAIDEN NAME <i>Louise Ellenberger</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-05-5771</i>		17. INFORMANT ADDRESS <i>Geraldine Gurry 734 E. Fort Ave.</i>	
18. <i>154.1 I</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>Carcinoma of Rectum</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>012-13-70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of Rectum</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (attify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-1</i> 19 <i>70</i> to <i>12-8</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>12-8</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A.C. Sollod M.D.</i>				23B. DATE SIGNED <i>12-9-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>A.C. SOLLOD M.D.</i>				23D. ADDRESS <i>707 Fort Ave. Balt., Md. 21230</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/11/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 10 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue</i>	

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5-18-08

1811/12 Cedar Hill Cemetery
Cemetery
1811/12 Cedar Hill Cemetery
Cemetery

FUNERAL DIRECTOR: IMPORTANT

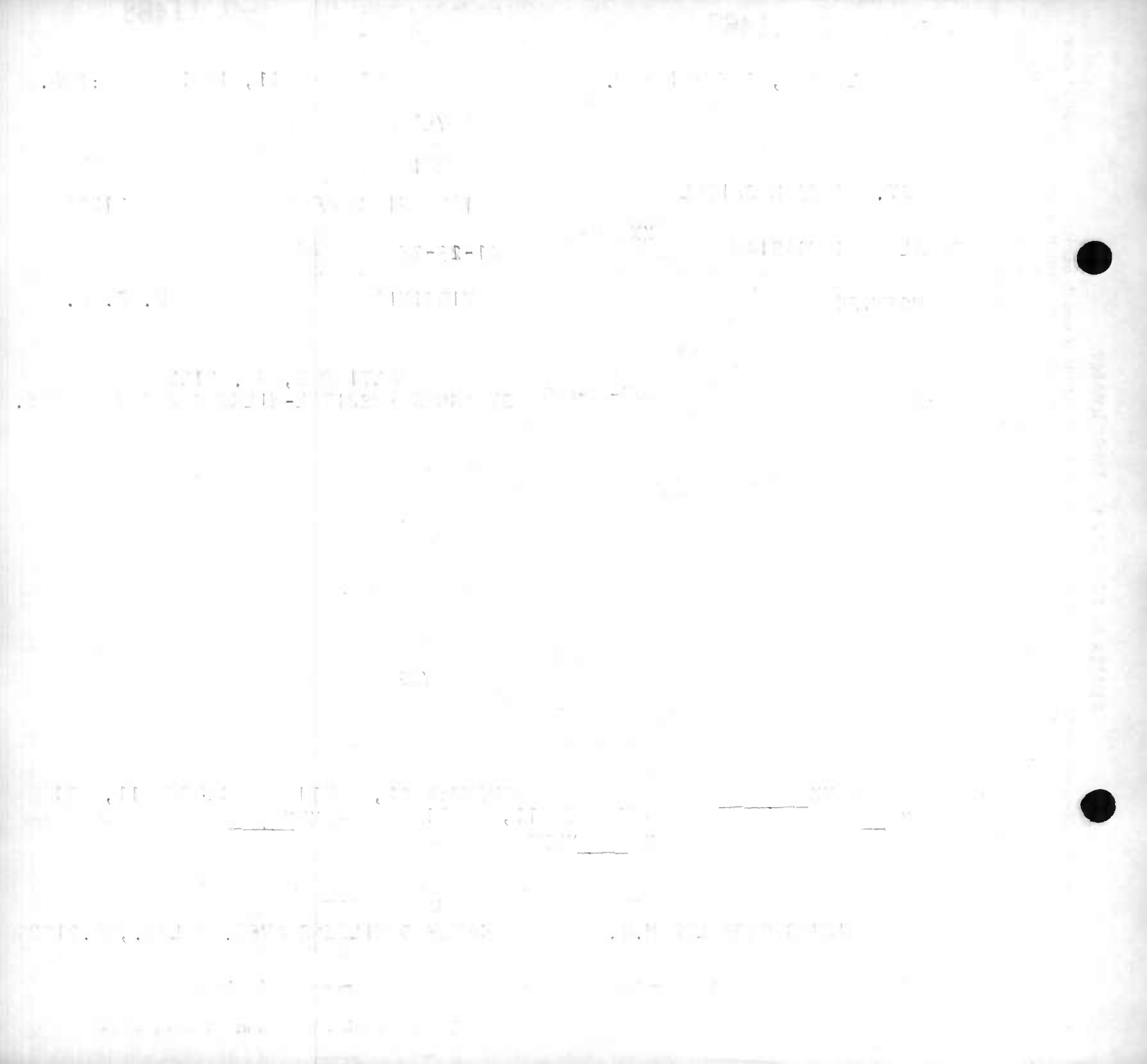
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		BALTIMORE CITY HEALTH DEPARTMENT		71 11467	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. 71 11467	
1. NAME OF DECEASED (Type or Print) <u>ALTON Hill</u>			2. DATE AND HOUR OF DEATH <u>12-9-71</u> <u>11 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4-6 Lutheran Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1506</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3020 W. North Ave</u>		
5. SEX <u>MALE</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-25</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Highway Dept</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNIK</u>			
14. MOTHER'S MARDEN NAME <u>UNIK</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNIK</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHART</u>			
18. <u>430.91</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory Center Failure</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Intracranial Hemorrhage</u> (Subarachnoid) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/1/71</u> 19__ to <u>12/9/71</u> 19__ that (I) (we) last saw the deceased alive on <u>12/9/71</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Amay - memon M.D.</u>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>ABDUL MAJID MEMON M.D.</u>		23D. ADDRESS <u>730 Ashburton St. Balto Md 21216</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>		24B. DATE <u>DEC 13 71</u>		24C. NAME of CEMETERY or CREMATORY <u>ARBUTAS</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTI MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1971</u>		25B. NAME OF REGISTRAR <u>John E. Vabey, M.D.</u>		25C. FUNERAL DIRECTOR <u>1 L BROWN, 123 W MONTGOMERY ST.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 11468	
L-625 71 11468		CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
LARSON, CATHERINE H.		DECEMBER 11, 1971 6:30A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
40 ST. AGNES HOSPITAL		MARYLAND BALTO 5300	
5. SEX FEMALE		6. RACE CAUCASIAN	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-23-25	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 46	
HOUSEWIFE		11. BIRTHPLACE (State or foreign country) VIRGINIA	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME late Davis		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 227-24-4554	
17. INFORMANT BALTIMORE, MD. 21229		ADDRESS ST AGNES HOSPITAL-WILKENS & CATON AVES.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of left lung</i> (B) <i>Generalized metastasis</i> (C)	
19. DATE OF OPERATION		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 22, 1971 to DECEMBER 11, 1971 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 11, 1971 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.		23A. SIGNATURE <i>Joung Soon Lee M.D.</i>	
23B. DATE SIGNED Dec. 11, 1971		23C. PHYSICIAN'S NAME (Type) JOUNG SOON LEE M.D.	
23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 12/14/71		24C. NAME of CEMETERY or CREMATORY Graham Cemetery	
24D. LOCATION (City, town, or county) (State) Orange, Virginia		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971	
25B. NAME OF REGISTRAR <i>Robert E. Jaber, M.D.</i>		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue, 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 11469	
CERTIFICATE OF DEATH					
BIRTH NO. H-626		11469			
1. NAME OF DECEASED (Type or Print) Doris Hargrove		2. DATE AND HOUR OF DEATH 12/9/71 11:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		A. STATE Maryland		B. COUNTY 909	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1616 Lamont Road			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/34	9. AGE (in years last birthday) 36	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frank Hargrove		14. MOTHER'S MAIDEN NAME Cledie Smith		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-28-1023		17. INFORMANT Mrs. Cledie Hargrove 1616 Lamont Ave.	
18. 569.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Cardiorespiratory arrest (C) 62 Bleeding					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/8 1971 to 12/9 1971 that (I) (we) last saw the deceased alive on 12/8 1971 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE R. B. Ryngaert M.D.		23B. DATE SIGNED 12/10		23C. PHYSICIAN'S NAME (Type) R. A. R. 221	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-71		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION Balto., Md.		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm C March 928 E. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11470	
CERTIFICATE OF DEATH					
BIRTH NO. G-160 71 11470					
1. NAME OF DECEASED (Type or Print) <u>Harry Geber</u>			2. DATE AND HOUR OF DEATH <u>Decem. 8, 1971 4:07 p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital, Baltimore</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2831</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4239 Labyrinth Rd.</u>		
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-14-04</u>	9. AGE (in years last birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>American U.S.A.</u>			13. FATHER'S NAME <u>David Geber</u>		
14. MOTHER'S MAIDEN NAME <u>XXXXXXX</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>MRS. MILDRED GEBER, 4239 LABYRINTH RD. #21215</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>pulmonary edema</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>acute MI</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>2 days</u>		
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Decem. 6</u> 19 <u>71</u> to <u>Decem. 8</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Decem. 8</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> view the body after death.					
23A. SIGNATURE <u>John Ols MD</u>				23B. DATE SIGNED <u>Decem. 8, 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>John Ols MD</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-9-71</u>		24C. NAME of CEMETERY or CREMATORY <u>BNAI ISRAEL</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1971</u>		25B. NAME OF REGISTRAR <u>Blues Geber, MD</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	

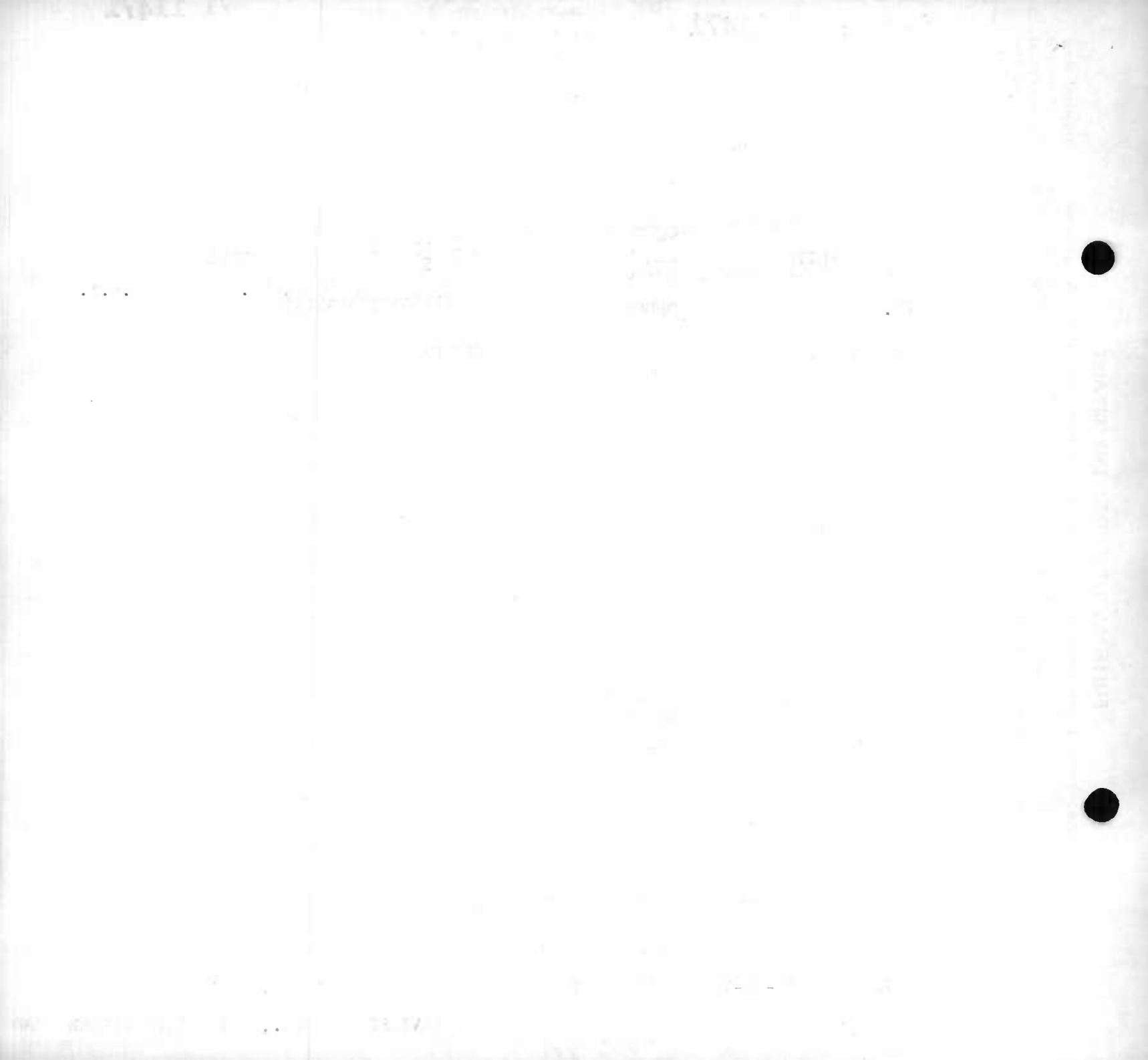
11/11/1961 10:00 AM



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

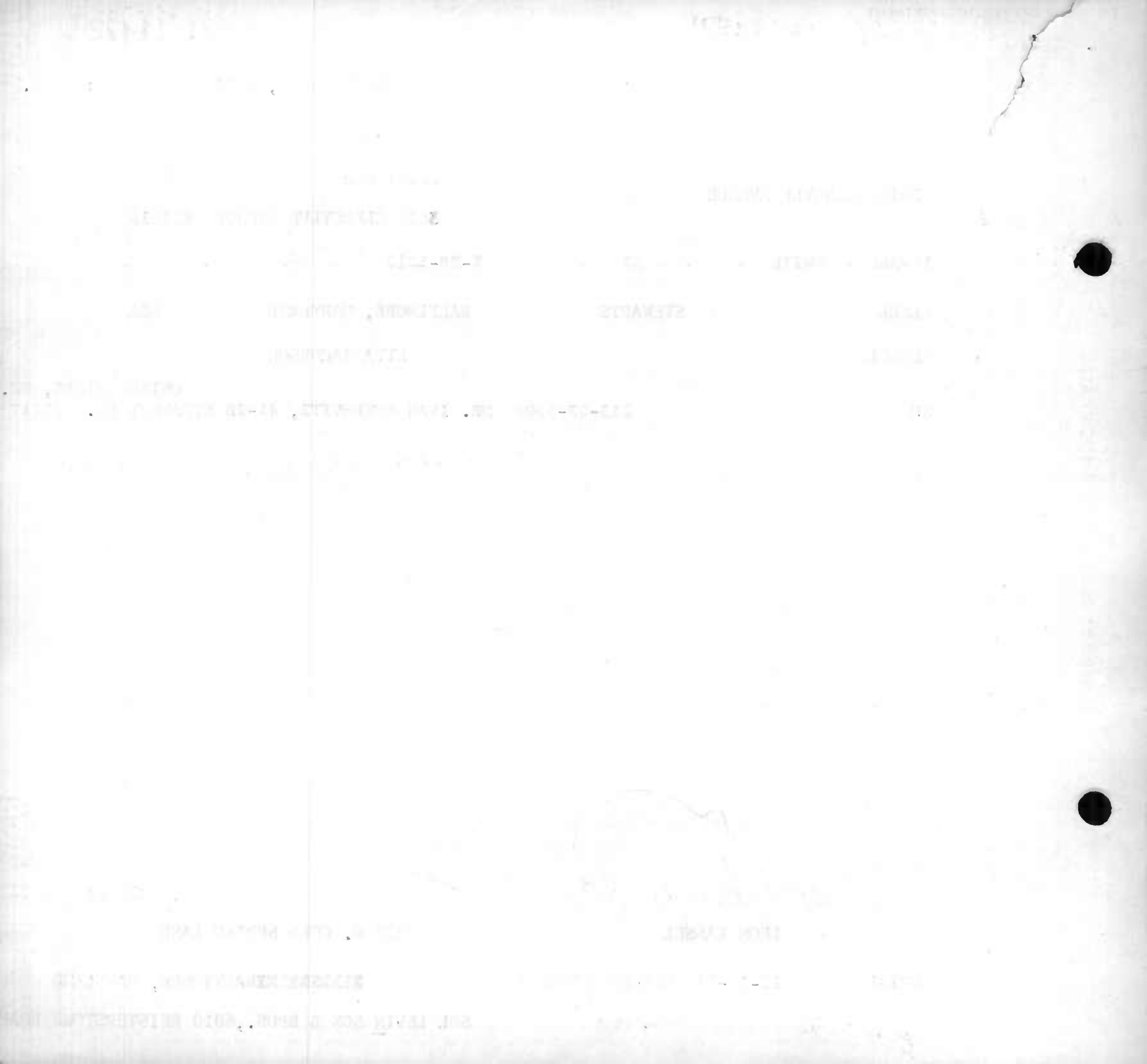
BALTIMORE CITY HEALTH DEPARTMENT				71 11471	
BIRTH NO. 8-160 71 11471				REG. NO.	
1. NAME OF DECEASED (Type or Print) HERMAN SHAPIRO			2. DATE AND HOUR OF DEATH 12-8-71 8.10p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 116 W UNIVERSITY PKWY		
5. SEX MALE	6. RACE WHITE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-XX-09	9. AGE (In years last birthday) 82	10. AGE (In years last birthday) XXXX
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MFG.		10B. KIND OF BUSINESS OR INDUSTRY DRUGS		11. BIRTHPLACE (State or foreign country) NORFOLK, VA.	
13. FATHER'S NAME ABRAM SHAPIRO			14. MOTHER'S MAIDEN NAME RIEDA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ESTHER SHAPIRO	
18. 436.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRO VASCULAR ACCIDENT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-1 19 71 to 12-8 19 71 that (I) (we) last saw the deceased alive on 12-8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juan M. Calderon M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JUAN M CALDERON M.D.				23D. ADDRESS JMH	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-10-71		24C. NAME of CEMETERY or CREMATORY HAR SINAI	
24D. LOCATION BALTIMORE, MA RYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971			
25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11472	
BIRTH NO. R-321 71 11472			
1. NAME OF DECEASED (Type or Print) DORIS ROTKOVITZ		2. DATE AND HOUR OF DEATH DECEMBER 9, 1971 6:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3616 GLENGYLE AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3616 GLENGYLE AVENUE #21215	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-1912 9. AGE (In years last birthday) 59
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY STEWARTS	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MENDEL		14. MOTHER'S MAIDEN NAME ETTA JACOBSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-6500	
		17. INFORMANT MR. IVAN ROTKOVITZ, 41-2B STRAWHAT RD, 21117 ADDRESS OWINGS MILLS, MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 157.9 CAUSE OF DEATH Carcinoma of Pancreas (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 6 mos (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Leon Kassel		23B. DATE SIGNED 12/10/71	
23C. PHYSICIAN'S NAME (Type) LEON KASSEL		23D. ADDRESS 222 W. COLD SPRING LANE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-10-71	
24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR SOL LEVIN SON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

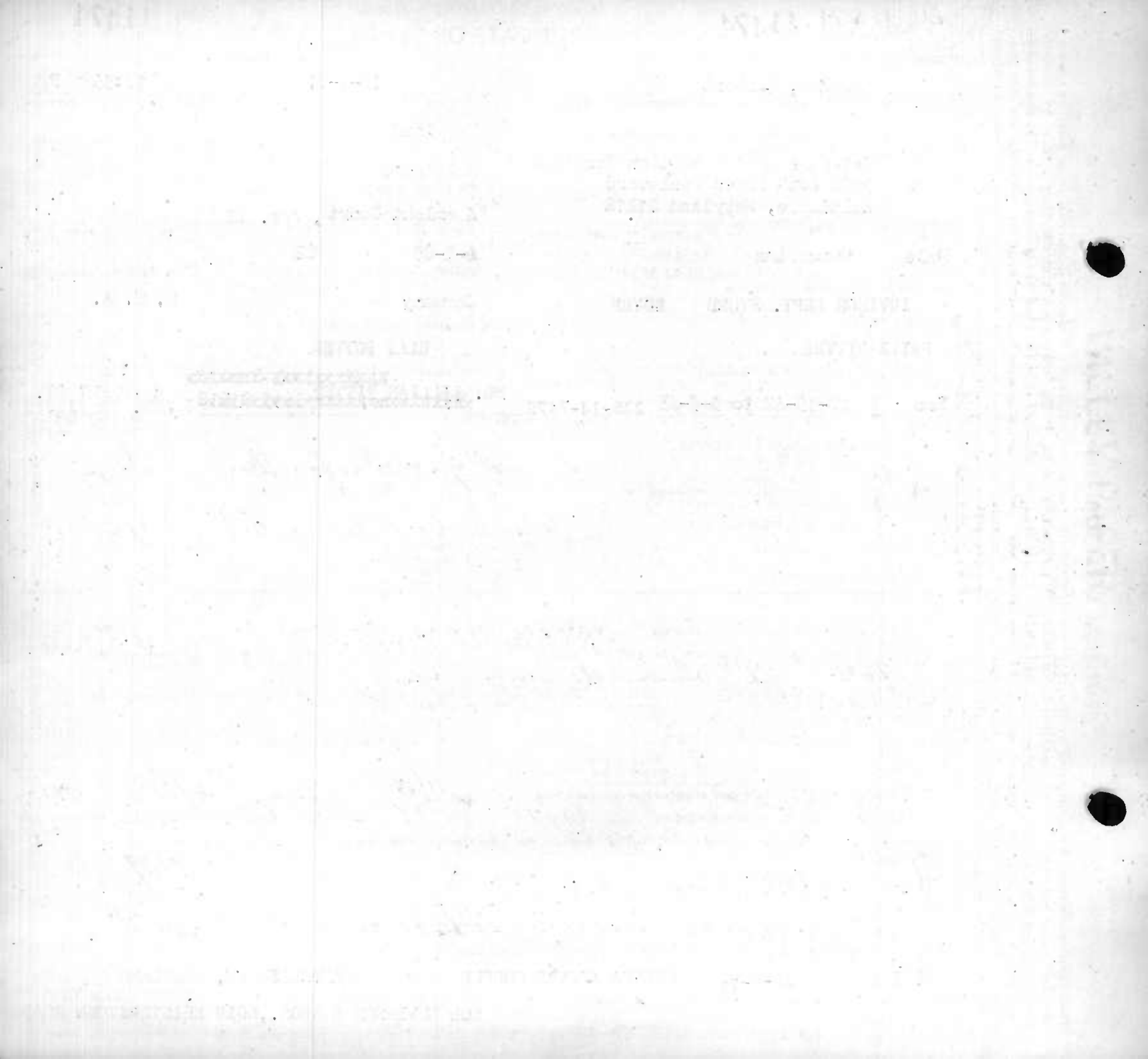
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11473	
<div style="display: flex; justify-content: space-between;"> C-162 71 11473 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MINNIE CHUPRECK			DECEMBER 8, 1971 7 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 6960 MARSUE DRIVE, APT. D			A. STATE MARYLAND		
			B. COUNTY BALTO 5300		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6960 MARSUE DRIVE, APT. D #21215		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 83	9. AGE (In years last birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		AT HOME		RUSSIA	USA
13. FATHER'S NAME SIDNEY SACHS			14. MOTHER'S MAIDEN NAME BESSIE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT MISS SADIE CHUPRECK, 6960 MARSUE DR., APT. D #15
NO					ADDRESS
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Psev d. (B) DUE TO, OR AS A CONSEQUENCE OF: Secondary arteriosclerosis (C) Pneumia		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 26 1970 to Dec 8 1971 , that (I) (we) lost saw the deceased alive on Dec 7 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nathan E. Needle				23B. DATE SIGNED Dec. 9, 1971	
23C. PHYSICIAN'S NAME (Type) NATHAN E. NEEDLE				23D. ADDRESS 6506 Park Heights Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-9-71		TIFERETH ISRAEL ANSHE SFARD	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
ROSEDALE, MARYLAND		DEC 13 1971		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
				SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

Wm. L. Garrison
Boston, Mass.

Richard L. Russell

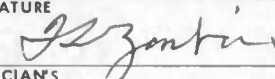
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

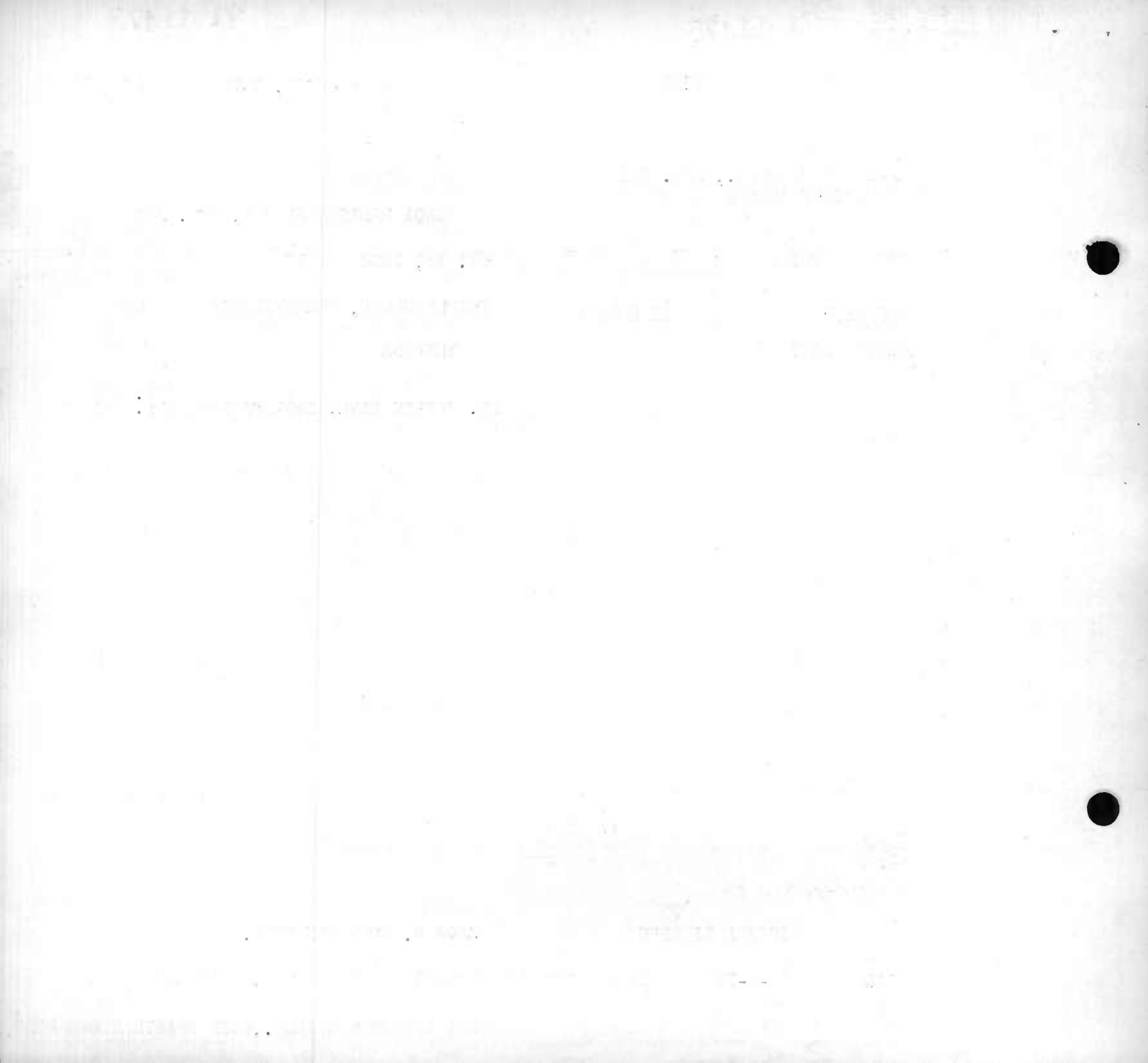
R-36071 11474		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 11474	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RITTER, Herbert		2. DATE AND HOUR OF DEATH 12-7-71 10:55 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 2X Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		E. STREET AND NUMBER 4 Amleht Court, Apt. T2		6. DATE OF BIRTH 4-2-09	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRVINGS DEPT. STORE		10B. KIND OF BUSINESS OR INDUSTRY BUYER		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME FRITZ RITTER		14. MOTHER'S MAIDEN NAME ELLI FUTTER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-15-42 to 5-5-43		16. SOCIAL SECURITY NO. 225-14-7475		17. INFORMANT Maximilian Ritter MR. LILLIAN RITTER 21215	
18. 410.94/62.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction		ADDRESS 4 AMLEHT CT. APT. T2 #21215	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic cardiovascular dis.		(B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic cardiovascular dis.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Adenocarcinoma of lung		(C) DUE TO, OR AS A CONSEQUENCE OF: Adenocarcinoma of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
19A. DATE OF OPERATION 2/9/64		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma of lung		20A. AUTOPSY? Yes or No yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 11/48	
22. I certify that (I) (this hospital) attended the deceased from 12/7 19 71 to 12/7 19 71 , that (I) (we) lost saw the deceased alive on 12/7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE Richard W. Mellinger, M.D.		23B. DATE SIGNED 12/8/71	
23C. PHYSICIAN'S NAME (Type) R. W. Mellinger, M.D.		23D. ADDRESS Loch Raven V. A. Hospital		23E. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-9-71		24C. NAME OF CEMETERY or CREMATORY CHEVRA ANAVAS CHESD	
24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR John E. Taylor, M.D.	



FUNERAL DIRECTOR: IMPORTANT

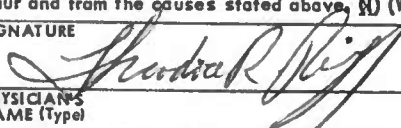
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. 71 11475
7-520 71 11475 BIRTH NO.				
1. NAME OF DECEASED (Type or Print) LEE GLATT FINK		2. DATE AND HOUR OF DEATH DECEMBER 7, 1971 12 Noon M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) TEMPLE GARDEN APTS., APT. 501 2601 MADISON AVENUE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1301 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2601 MADISON AVENUE, APT. 501		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 16, 1894	9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) CHAMBERSBURG, PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MORRIS GLATT		
14. MOTHER'S MAIDEN NAME THERESA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT MR. JOSEPH FINK, 2601 MADISON AVE. #21217		
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Auto Myocard Infarction DUE TO, OR AS A CONSEQUENCE OF: 1 day		
(B) H A S H I D DUE TO, OR AS A CONSEQUENCE OF: 157 years		(C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) _____				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 7/19 19 50 to 12/7 19 71 , that (I) (we) lost saw the deceased alive on 1/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE  DEGREE _____				23B. DATE SIGNED 12/7/71
23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG		23D. ADDRESS 4000 W. NORTHERN PKWY.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12-9-71	24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR SOL LEVINSON	25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 11476</u>	
BIRTH NO. <u>R-150 71 11476</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MORRIS RUBIN</u>			2. DATE AND HOUR OF DEATH <u>December 7, 1971</u> <u>6:20 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 LEVINDALE</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2717</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>LEVINDALE</u>		
5. SEX <u>Male</u>	6. RACE <u>WHITE</u> Human	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 17, 1884</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HARDWARE</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
13. FATHER'S NAME <u>SAMUEL RUBIN</u>			14. MOTHER'S MAIDEN NAME <u>LEAH ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MRS. CELE RASIN, WILTONWOOD RD., STEVENSON, MD.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Left Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Gangrene of Bowel</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Urinary Tract Infection due to Suprapubic Cystotomy</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>_____ days</u> <u>_____ Weeks</u>		
19A. DATE OF OPERATION <u>22</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>June 28, 1965</u> to <u>December 7, 1971</u> that <u>(N)</u> (we) last saw the deceased alive on <u>December 7, 1971</u> and that <u>(N)</u> (our) opinion death occurred on the date <u>and hour and from the causes stated above.</u> (N) (We) (did) <u>NOT</u> view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED <u>12-8-1971</u>		23C. PHYSICIAN'S NAME (Type) <u>Theodore R. Reiff, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>12-9-71</u>		24C. NAME of CEMETERY or CREMATORY <u>BETH HAMEDROSH HAGODOL</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1971</u>			25B. NAME OF REGISTRAR <u>E. M. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>
24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>			25D. ADDRESS <u>Levindale</u>		

2434 *Handwritten text*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 11477</u>	
BIRTH NO. <u>W-425 71 11477</u>				1. NAME OF DECEASED (Type or Print) <u>Wilson, Hester M.</u>		2. DATE AND HOUR OF DEATH <u>12/6/71</u> <u>3:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2646</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital Inc.</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>6123 Danville Ave. 21224</u>			
5. SEX <u>Female.</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/19/04</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eli H. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Hester Baker</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-14-1947</u>		17. INFORMANT <u>Mercy Hospital Staff</u>		ADDRESS <u>301 St. Paul Pl.</u>	
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Artery disease</u> <u>Diabetes, Cirrhosis & aorta</u>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>12/6/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> <u>1971</u> to <u>12/6</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>12/6</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Claudius Klimt</u>				23B. DATE SIGNED <u>12/6/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Claudius Klimt M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Dec 9, 1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Middletown Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>James J. Stattenstein</u>		ADDRESS <u>Har. Exodon, Pa.</u>	

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Don't know

Don't know

Don't know

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">N-200 71 11478</h2>		<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2>		<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		<h2 style="margin: 0;">REG. NO. 71 11478</h2>	
1. NAME OF DECEASED (Type or Print) Nash, William Thomas				2. DATE AND HOUR OF DEATH 12/9/72 12-9-1971 2:20 P.M. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Pleasant Manor Nursing Home 4615 Park Heights Avenue Baltimore, Maryland 21215				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland , B. COUNTY Baltimore C. CITY OR TOWN Granite D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Davis Avenue and 21163			
5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH July 8, 1900 9. AGE (in years last birthday) 71 10. If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Apt. House Owner and Operator				11. BIRTHPLACE (State or foreign country) Granite, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Nash				14. MOTHER'S MAIDEN NAME Emma M. Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I				16. SOCIAL SECURITY NO. 199-01-0814 17. INFORMANT Davis Avenue ADDRESS Mrs. Olga Nash, Granite, Maryland 21163			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Myocardial infarction Sudden Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ① arterial hypertension ② arterial atherosclerosis ③ and old myocardial infarction 10 yrs (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic COO Disease (C) CA of prostate w/ metastasis 3 yrs				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CA of prostate w/ metastasis 3 yrs			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 12/8/71 to 12/9/71 19 71 and that (I) (we) lost saw the deceased alive on 12/8/71 19 71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Thomas Conception	
23B. PHYSICIAN'S NAME (Type) Thomas Conception		23C. ADDRESS 3502 West Rogers Avenue		23D. DATE SIGNED 12/9/71		23E. DEGREE MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/1971		24C. NAME of CEMETERY or CREMATORY Granite Presbyterian Cemetery		24D. LOCATION (City, town, or county) (State) Granite, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR 8728 Liberty Rd. Address 21133		25D. ADDRESS Louise B. B. Funeral Directors, PA	

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T-320 71 11479 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 11479

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anthony L. Bates		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> 12, 4, 1971 1:00 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 McDonough & Biddle Street		3. DATE PRONOUNCED DEAD Month 12, Day 4, Year 1971 8:25 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 808	
9. DATE OF BIRTH 11/26/50		10. AGE (In years lost birthday) 21	
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Earl Fletcher		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Rosie Bates		16. KIND OF BUSINESS OR INDUSTRY	
17. SOCIAL SECURITY NO. 212-48-1465		18. INFORMANT Rosie Harrison 1012 N. Durham St	
19. 304.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Narcotic addiction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/4/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/71	
24C. NAME of CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A. A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Joseph G. Locks		ADDRESS 1304 N. Central Ave	

VS 151-REV. 1/1/68

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-526 71 11480		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11480	
CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Milton H. Winaker</i>			2. DATE AND HOUR OF DEATH <i>12 - 9 - 1971 12 45 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			A. STATE <i>Md</i> B. COUNTY <i>Balto</i>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN <i>Cockeysville</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <i>10329 Malcolm Circle, Cockeysville</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>08-12-10</i>	9. AGE (In years last birthday) <i>61</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Dist. Sales Manager</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Louis Winaker</i>			14. MOTHER'S MAIDEN NAME <i>Ada Winaker</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-07-7630</i>		17. INFORMANT <i>Mrs. Theresa S. Winaker</i>	
				ADDRESS <i>Cockeysville, Md.</i>	
18. <i>430.91</i> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Involuntarily medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-05-1971</i> to <i>12-09-1971</i> that (I) (we) last saw the deceased alive on <i>12-09-1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>TULLIO BRADORINI</i>				23B. DATE SIGNED <i>Dec 9, 1971</i>	
23C. PHYSICIAN'S NAME (Type) <i>TULLIO BRADORINI</i>				23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec. 13, 71</i>		24C. NAME of CEMETERY or CREMATORY <i>Meadowridge Memorial</i>	
24D. LOCATION <i>Howard Co. Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>DEC 13 1971</i>		24F. NAME OF REGISTRAR <i>Robert E. Fisher, Md.</i>	
24G. FUNERAL DIRECTOR <i>Eline Funeral Home</i>		24H. ADDRESS <i>Reisterstown, Md.</i>		24I. DATE <i>DEC 13 1971</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-630 71 11481				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11481	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HEERD, EDNA M.				2. DATE AND HOUR OF DEATH 12-8-1971 4.30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1306			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BAITO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/94	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY SEAMSTRESS		9. AGE (In years last birthday) 77		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME EDMOND D. SMITH				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-10-4811		17. INFORMANT BERNETT, M. SAUER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) SEPTICEMIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CELLULITIS				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/30/1971 to 12/8/1971 that (I) (we) last saw the deceased alive on 12/8/1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Carlos A. Bottilana MD				23B. DATE SIGNED 12-8-1971		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) CARLOS A. BOTTILANA				23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-11-71		24C. NAME OF CEMETERY or CREMATORY London Rd		24D. LOCATION (City, town or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR DESS, Mary		25C. FUNERAL DIRECTOR Frank W. Sartz		ADDRESS 814 N 36th St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 71 11482 BIRTH NO. 71 11482 CERTIFICATE OF DEATH				REG. NO. 71 11482	
1. NAME OF DECEASED (Type or Print) MOLLIE HARMAN HILLYARD			2. DATE AND HOUR OF DEATH DECEMBER 8, 1971 2 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 8 Club Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2714 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8 Club Road 21210		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1880	9. AGE (In years last birthday) 91	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Staunton Virginia
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Robert Otho Haines		
14. MOTHER'S MAIDEN NAME Lillian Earl Staples			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 220 54 0238 H.T.			17. INFORMANT ADDRESS Mrs Jean Hofmeister 8 Club Road		
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anger's true heart failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. ASCD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Feb 67 to Dec 8 71 , that (I) (we) last saw the deceased alive on Dec 6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William G. Helfrich		23B. DATE SIGNED Dec. 9, 1971		23C. PHYSICIAN'S NAME (Type) William G. Helfrich M.D.	
23D. ADDRESS 5006 Roland Avenue Balto. Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12/11/71		24C. NAME OF CEMETERY or CREMATORY Mount Hebron Cemetery		24D. LOCATION (City, town, or county) (State) Winchester Virginia	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR Robert E. Hays, M.D.		25C. FUNERAL DIRECTOR ADDRESS Henry Sander & Sons Inc. Baltimore Maryland 21213	

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/01 BY 60322 UCBAW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 11483	
G-626 71 11483 BIRTH NO. 1. NAME OF DECEASED (Type or Print) ANDY W. GREGORY		2. DATE AND HOUR OF DEATH 12-10-71 4:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1513 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3514 VIRGINIA AVENUE			
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-19-1989	9. AGE (in years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Sheet Metal Worker - Am. Sugar Co.		10B. KIND OF BUSINESS OR INDUSTRY Coben White Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Malachi Gregory		14. MOTHER'S MAIDEN NAME Eugenia (Moroscho)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 207-09-5318 A		17. INFORMANT ADDRESS Mr. Sylvester Gregory 3514 Virginia Ave. 15	
18. 436.9 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA				(B) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF:	
(C)				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-08 1971 to 12-10 1971 that (I) (we) last saw the deceased alive on 12-10 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter Oroszlan				23B. DATE SIGNED 12-10-71	
23C. PHYSICIAN'S NAME (Type) PETER OROSZLAN MD		23D. ADDRESS 3 HAVILL RD, APT 5			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/1971		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1971			
25B. NAME OF REGISTRAR Robert J. Ryan		25C. FUNERAL DIRECTOR Robert J. Ryan ADDRESS 21153 Liberty Rd			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 11484	
W-300 71 11484					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) William E. White			2. DATE AND HOUR OF DEATH 12/9/71 6:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY 2102		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hosp.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M. 6. RACE W. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1/22/1898		9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cable Maker			10B. KIND OF BUSINESS OR INDUSTRY B.O. R.R.		11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Wm. E. White, Sr.		
14. MOTHER'S MAIDEN NAME ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. -			17. INFORMANT Ocie White 310 S. Poppleton St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) Ca lung			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory failure			(B) DUE TO, OR AS A CONSEQUENCE OF: 1 hr.		
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/9/71 to 12/9/71, that (I) (we) last saw the deceased alive on 12/9/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Munses				23B. DATE SIGNED 12/10/71	
23C. PHYSICIAN'S NAME (Type) SILVINO B. MUNSES M. D. 2232 HAMILTOWNE CIRCLE				23D. ADDRESS DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/71		24C. NAME OF CEMETERY or CREMATORY Cah Lawn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, MD		24E. LOCATION (City, town, or county) (State) Dorress Co. Indiana		24F. LOCATION (City, town, or county) (State) St.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR John J. Edwards		25C. FUNERAL DIRECTOR John J. Edwards	
25D. ADDRESS 232nd.					

18:11 15

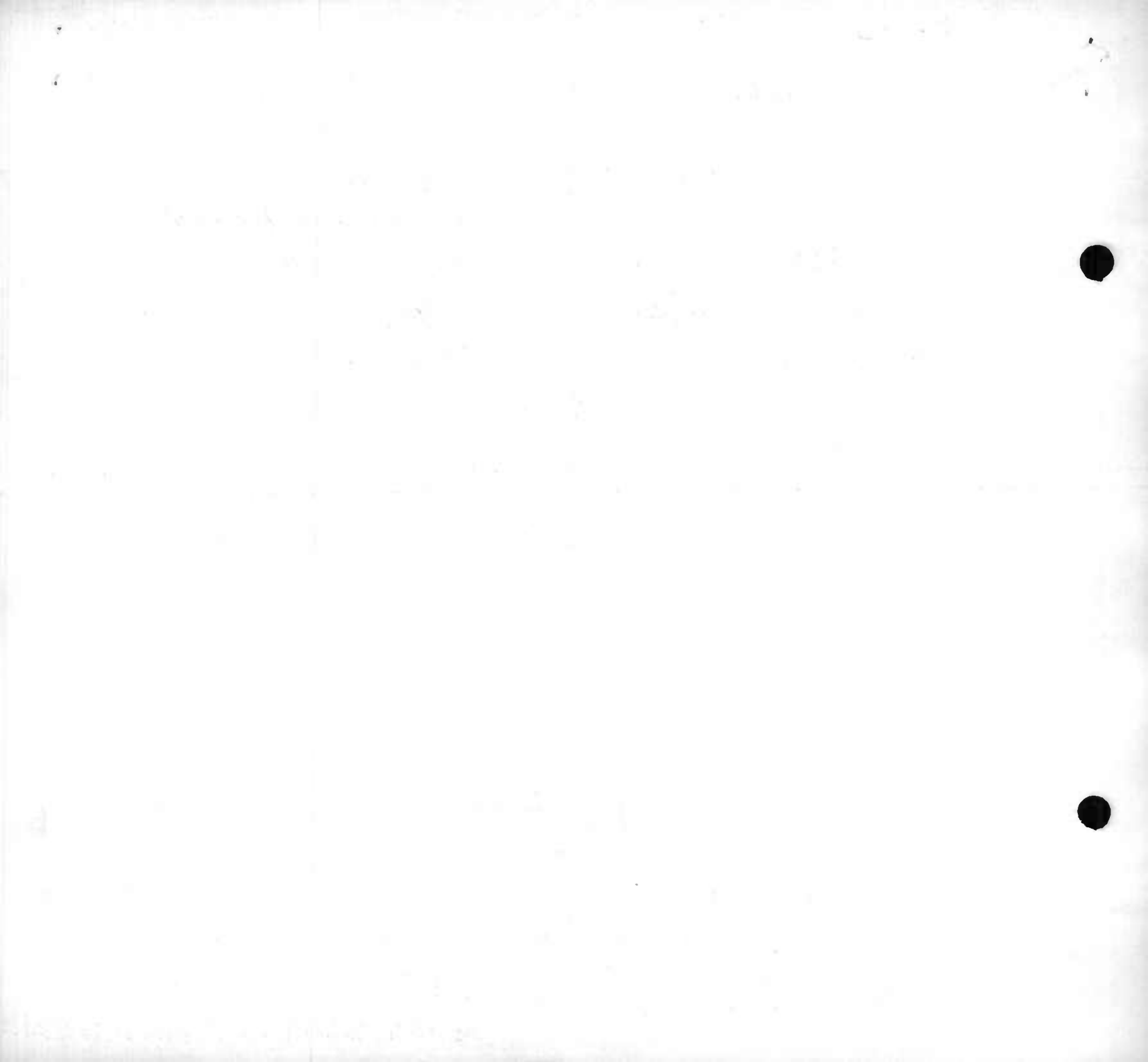
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120		71 11485		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11485	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DAVAGE, LILLIAN A.				2. DATE AND HOUR OF DEATH 12/9/71 11:55 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital				A. STATE Md.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY Balts.			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3609 HARMON AVENUE							
5. SEX F	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/89	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JAMES JENKINS				14. MOTHER'S MAIDEN NAME ELIZA ROBERTSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT patient's chart	
18. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
(B) Coronary atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____							
19A. DATE OF OPERATION 12/13/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/3 19 71 to 12/9 19 71 that (I) (we) last saw the deceased alive on 12/9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rufino G. Montenegro				23B. DATE SIGNED 12/9/71		23C. PHYSICIAN'S NAME (Type) RUFINO G. MONTENEGRO	
23D. ADDRESS 2724 North Charles St. Balts. Md.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/13/71		24C. NAME of CEMETERY or CREMATORY Arbuthnot Mem. PK.		24D. LOCATION (City, town, or county) (State) Balts. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR Robert F. Taylor, M.D.		25C. FUNERAL DIRECTOR Matthews Funeral Home		25D. ADDRESS 1701 W. Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11486	
BIRTH NO. V-230 71 11486		1. NAME OF DECEASED (Type or Print) VEST, FLORENCE MARIE		2. DATE AND HOUR OF DEATH 12-09-71 7:55AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY XX AA CO			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION WILKENS & CATON AVE. BALTIMORE MARYLAND 21229		C. CITY OR TOWN SEVERN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER BOX 268 RT 1 QUARTERFIELD RD SEVERN			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 12 92	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME Frederick Hauser				14. MOTHER'S MAIDEN NAME Mary E. (unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO None		16. SOCIAL SECURITY NO. 214225620		17. INFORMANT ADDRESS ST AGNES RECORDS-WILKENS & CATON AVE.			
18. 470.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Cardiogenic shock</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute antero-septal myocardial infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Atherosclerotic Cardiovascular Disease</i> (C) <i>Status paces maker, permanent</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 25 19 71 to DECEMBER 9 19 71 that (X) (we) last saw the deceased alive on DECEMBER 9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Perfecto Valarao</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-9-71	
23C. PHYSICIAN'S NAME (Type) PERFECTO VALARAO				23D. ADDRESS ST AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/71		24C. NAME of CEMETERY or CREMATORY Glen Haven Mem'l Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>Singleton</i>		ADDRESS Singleton Funeral Home, Glen Burnie, Md.	

2160 2870 17 17

[illegible]

0.71	0.80	0.81	0.82	0.83	0.84	0.85	0.86	0.87	0.88	0.89	0.90	0.91	0.92	0.93	0.94	0.95	0.96	0.97	0.98	0.99	1.00
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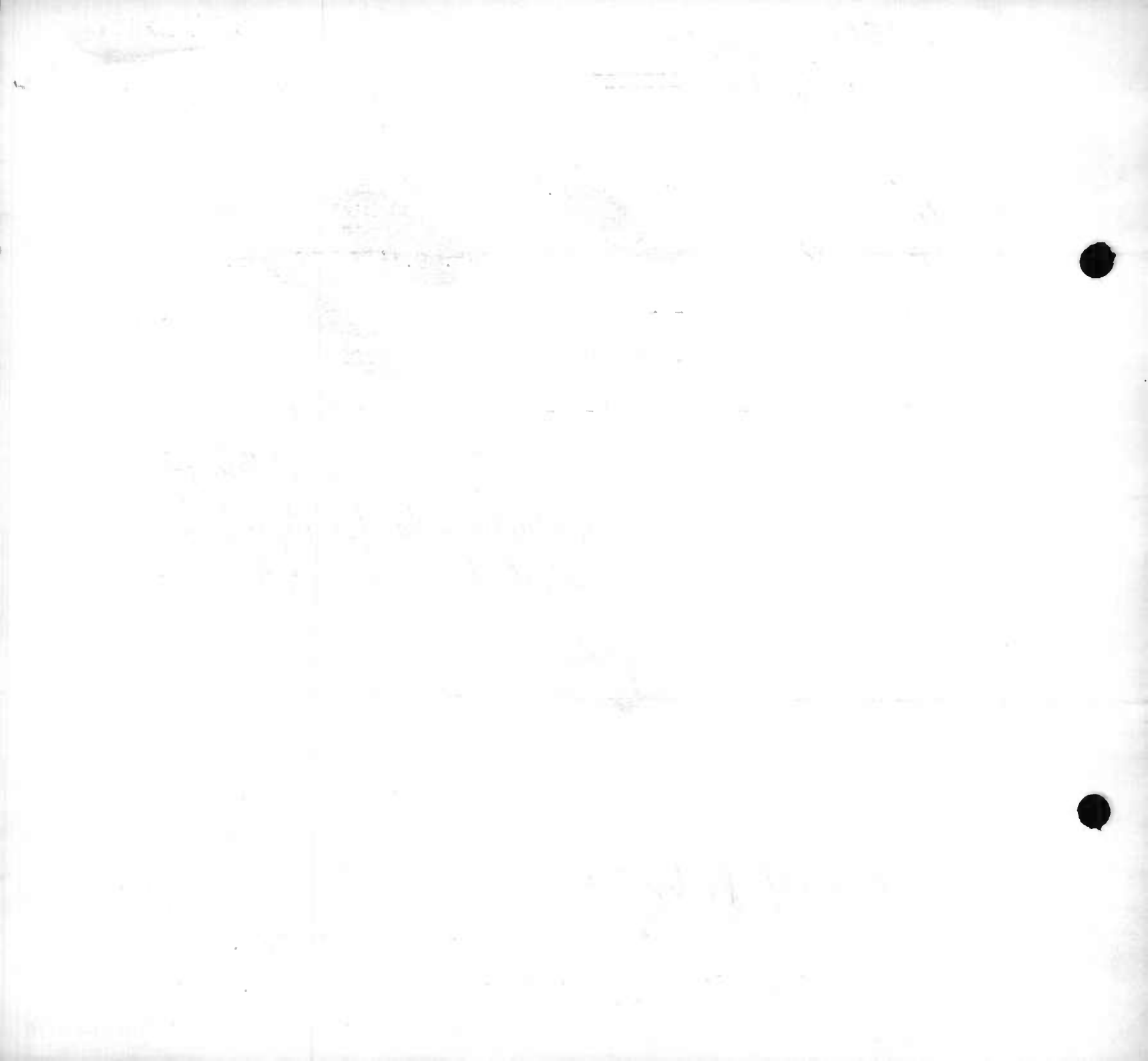
2-1-

— 2 —

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 11487	
L-230 71 11487 BIRTH NO.			
1. NAME OF DECEASED (Type or Print) ELIZABETH LECATO Le Cato		2. DATE AND HOUR OF DEATH 12/9/71 9:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1307 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3700 Hickory Avenue 21211	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1937
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY - -	9. AGE (In years last birthday) 34 yrs. If Under 1 Yr. Months Days If Under 24 Hrs. Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles A. Arnold		14. MOTHER'S MAIDEN NAME Huff	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - -		16. SOCIAL SECURITY NO. 214-40-0978	
17. INFORMANT George Le Cato		ADDRESS 3700 Hickory Ave	
18. I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <i>Carcinoma of Breast</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Metastasis to Lung + Liver</i> (B) <i>Multiphase Pulmonary Emboli probably</i> (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/26/71 19 to 12/8/71 19 that (I) (we) last saw the deceased alive on 11/9/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Donald Huff</i>		23B. DATE SIGNED 12/9/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Maryland Gen'l Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/71	
24C. NAME OF CEMETERY OR CREMATORY Crest Lawn Gardens		24D. LOCATION (City, town, or county) (State) Howard Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR <i>Robert S. J. [illegible]</i>	
25C. FUNERAL DIRECTOR Dohovan		ADDRESS Funeral Home 3818 Roland Ave	



S-543

71 11488

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 11488

BIRTH NO.

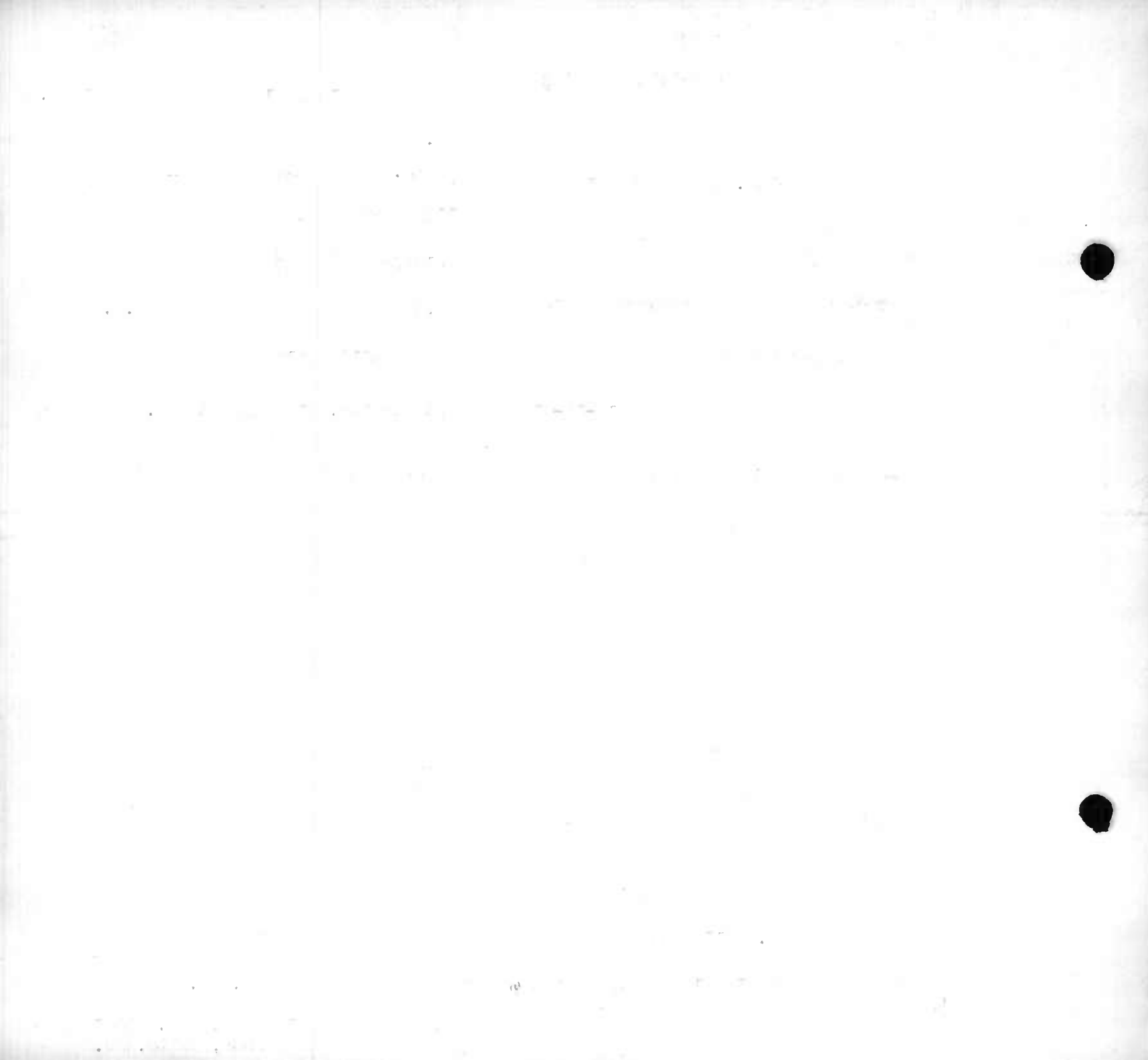
1. NAME OF DECEASED (Type or Print) MARTHA SMELTER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL OR INSTITUTION 610 N. Luzerne Avenue		3. DATE PRONOUNCED DEAD Month Day Year December 8, 1971 Hour 12:58 P.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/13/84		10. AGE (In years lost birthday) 87 86	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		14B. KIND OF BUSINESS OR INDUSTRY at home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 218-50-6056-T	
18. INFORMANT Leonard Smelter (son)		ADDRESS Edgewood Md. 21040	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 12/11/71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/9/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/11/71	
24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213		ADDRESS	

[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

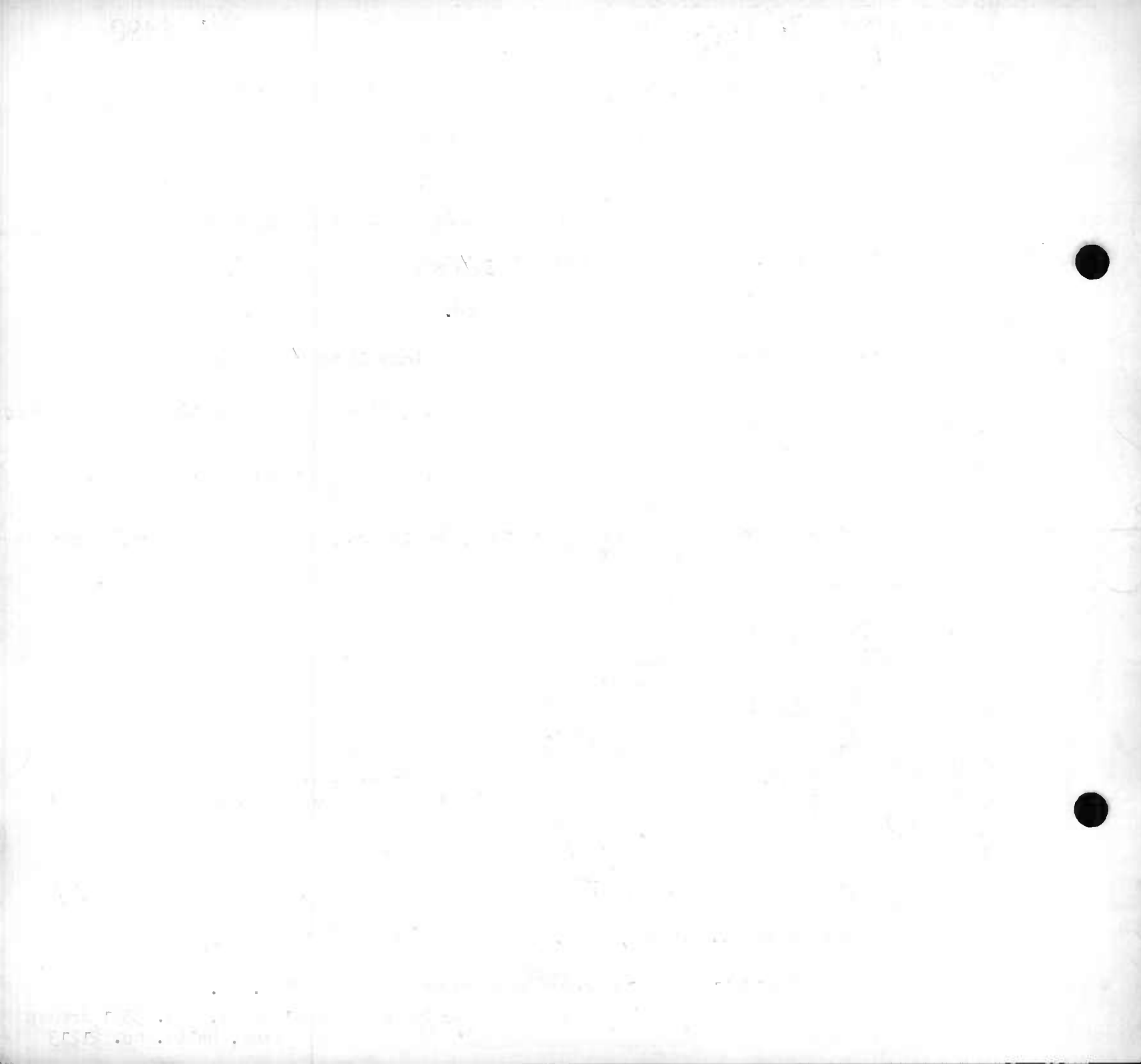
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11489	
BIRTH NO. 11489		CERIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Lula Patricia Jenkins		2. DATE AND HOUR OF DEATH 12/7/71 1 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Balto. City Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 2634	
		C. CITY OR TOWN Balto.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1140 Newcomb Way	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19/25
9. AGE (in years last birthday) 46		10. UNDER 1 Yr. Months Days 11	11. UNDER 24 Hrs. Hours Min. 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10B. KIND OF BUSINESS OR INDUSTRY Southern Envelope	11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James Keatts	
14. MOTHER'S MAIDEN NAME Nellie Tyler		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 218-18-0102		17. INFORMANT Ruth Taylor, 5198 Wright Ave. (sister)	
18. 183.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH SEROUS CARCINOMA OF OVARIES (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
21A. DATE OF OPERATION 0	21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21C. AUTOPSY? (Yes or No)	21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9-17-70 19 to 12-2-71 19 that (1) was last saw the deceased alive on 12-2-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Villa Santa		23B. DATE SIGNED 12-8-71	
23C. PHYSICIAN'S NAME (Type) Dr. Villa Santa		23D. ADDRESS 22 S. GREENE ST. BALTIMORE Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12/10/71	24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971	25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.	25D. ADDRESS 3331 Brehms Inam, Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

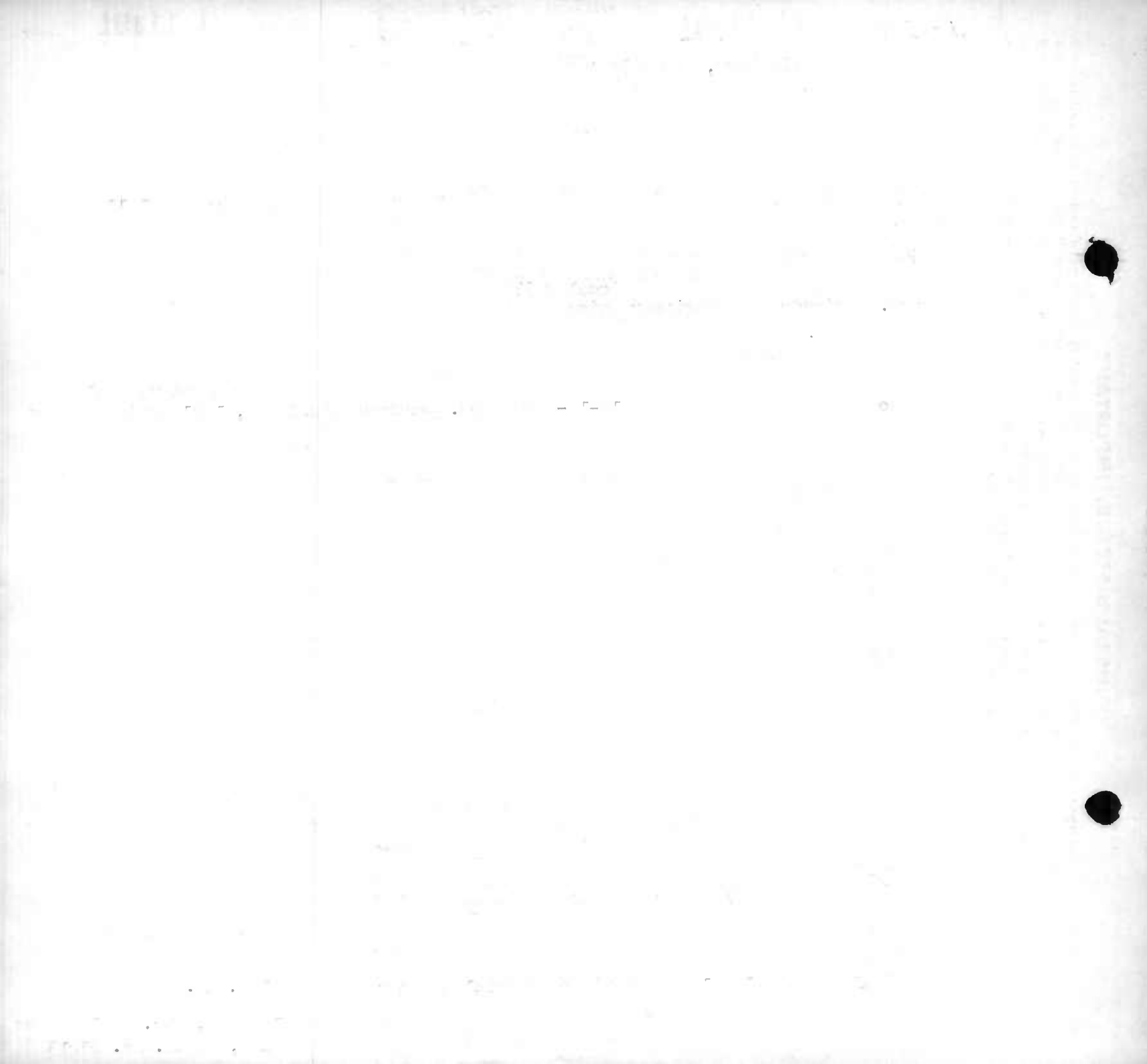
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11490	
M-650 71 11490		BIRTH NO. Balt 71 11490		1. NAME OF DECEASED (Type or Print) Kellie Mauerhan	
2. DATE AND HOUR OF DEATH Dec. 7, 1971 7:00 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2735		5. SEX Female 6. RACE Cauc.			
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3512 Northern Parkway		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3/2/18/70		9. AGE (in years last birthday) 1 1/2		10. UNDER 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Albert Mauerhan		14. MOTHER'S MAIDEN NAME Mary Linda X Spencer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Linda Mauerhan (mother) same address	
18. 273.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cystic Fibrosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure (B) Cystic Fibrosis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. 6 1/2 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (1) (this hospital) attended the deceased from 11/17 19 71 to 12/7 19 71 that (1) (we) last saw the deceased alive on 12/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Katherine C. Teets				23B. DATE SIGNED 12/7/71	
23C. PHYSICIAN'S NAME (Type) Katherine C. Teets, M.D.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/10/71		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schmunk Funeral Homes, Inc.		25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 11491</u>	
<div style="display: flex; justify-content: space-between;"> <u>L-516</u> <u>71 11491</u> </div>							
1. NAME OF DECEASED (Type or Print) <u>Lymberg, Bartholomeus</u>				2. DATE AND HOUR OF DEATH <u>Dec 7 1971</u> <u>11:17 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>UNION MEMORIAL HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Balto Md</u> B. COUNTY <u>1207</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				E. STREET AND NUMBER <u>2626 Miles Ave 21211</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>01-25-10</u>	9. AGE (in years last birthday) <u>61</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Const. Engineer</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Local # 37 Engineer Union</u>		11. BIRTHPLACE (State or foreign country) <u>HOLLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>216-16-8558</u>				17. INFORMANT <u>Mrs. Gertrude Miskimmon, 1231 Armistead Way</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>303.9 I</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Aspiration pneumonia hours</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Alcoholism - w.t.</u> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>							
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 7</u> 19 <u>71</u> to <u>Dec 7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Dec 7</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>Dec 7, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>TULLIO BARTORINI</u>	
23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/10/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Memorial Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>		25D. ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>	



Consider person made by funeral home

FUNERAL DIRECTOR: IMPORTANT

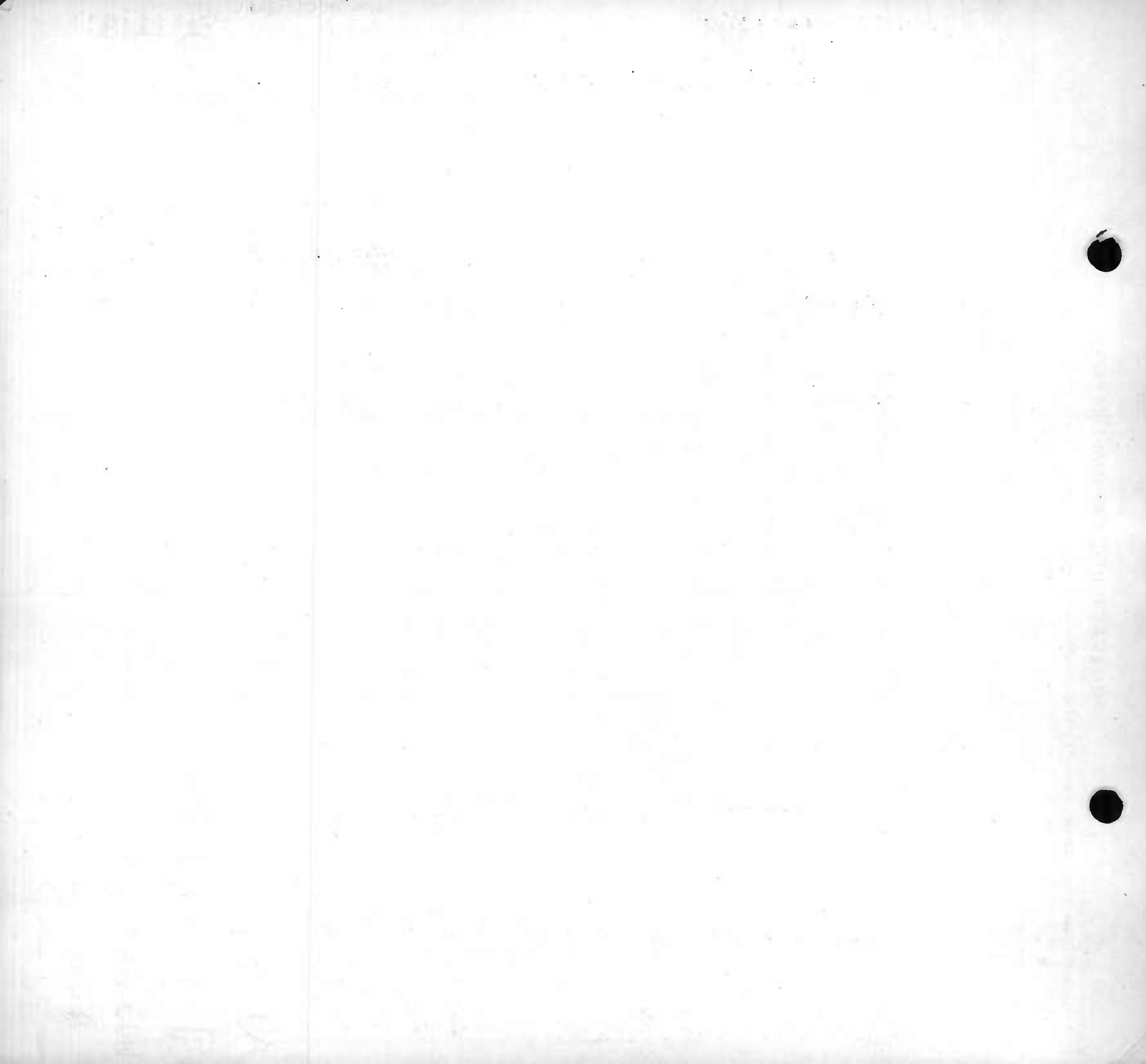
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>D-200 71 11492 CERTIFICATE OF DEATH REG. NO. 11492 X</p>	
<p>BIRTH NO. (DACHNIE WICZ)</p>	
<p>1. NAME OF DECEASED (Type or Print) DACK, Joseph Louis</p>	
<p>2. DATE AND HOUR OF DEATH 9/10/71 4:50 PM 5300 M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MD B. COUNTY BALTIMORE 21222</p>	
<p>5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 4</p>	
<p>E. STREET AND NUMBER 6814 - BENCLARE R.D.</p>	
<p>6. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITAL 4940 Eastern Ave. Baltimore, Md.</p>	
<p>5. SEX Male 6. RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 8-9-91 9. AGE (In years last birthday) 80 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER 11. BIRTHPLACE (State or foreign country) Maryland AUSTRIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME JOHN DACHNIEWICZ 14. MOTHER'S MAIDEN NAME - UNK -</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 16. SOCIAL SECURITY NO. WNI 213-07-5536 17. INFORMANT BCH Records: Baltimore, Md. 21224 ADDRESS 4940 Eastern Ave.</p>	
<p>18. CAUSE OF DEATH BRONCHOPNEUMONIA congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>	
<p>ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)</p>	
<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ascarid.</p>	
<p>(B) DUE TO, OR AS A CONSEQUENCE OF: Liver cirrhosis - 5 YEARS</p>	
<p>(C) DUE TO, OR AS A CONSEQUENCE OF: Ca of prostate metastases. 2 YEARS</p>	
<p>II</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) - 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) - 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? -</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 10/14 19 to 2/10/71 19 that (I) (we) last saw the deceased alive on 2/9/71 19 and that in (my) (our) opinion death occurred on the date 2/9/71 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE LMC 23B. DATE SIGNED 9/10/71 23C. PHYSICIAN'S NAME (Type) LOUIS CARRILLO 23D. ADDRESS BALTIMORE CITY HOSPITAL 4940 Eastern Ave. Baltimore, Md.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 12/13/71 24C. NAME OF CEMETERY OR CREMATORY OAKLAWN 24D. LOCATION (City, town, or county) (State) BALTO. CO. MD</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR Adolphus Bradley, D.D. ADDRESS -</p>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

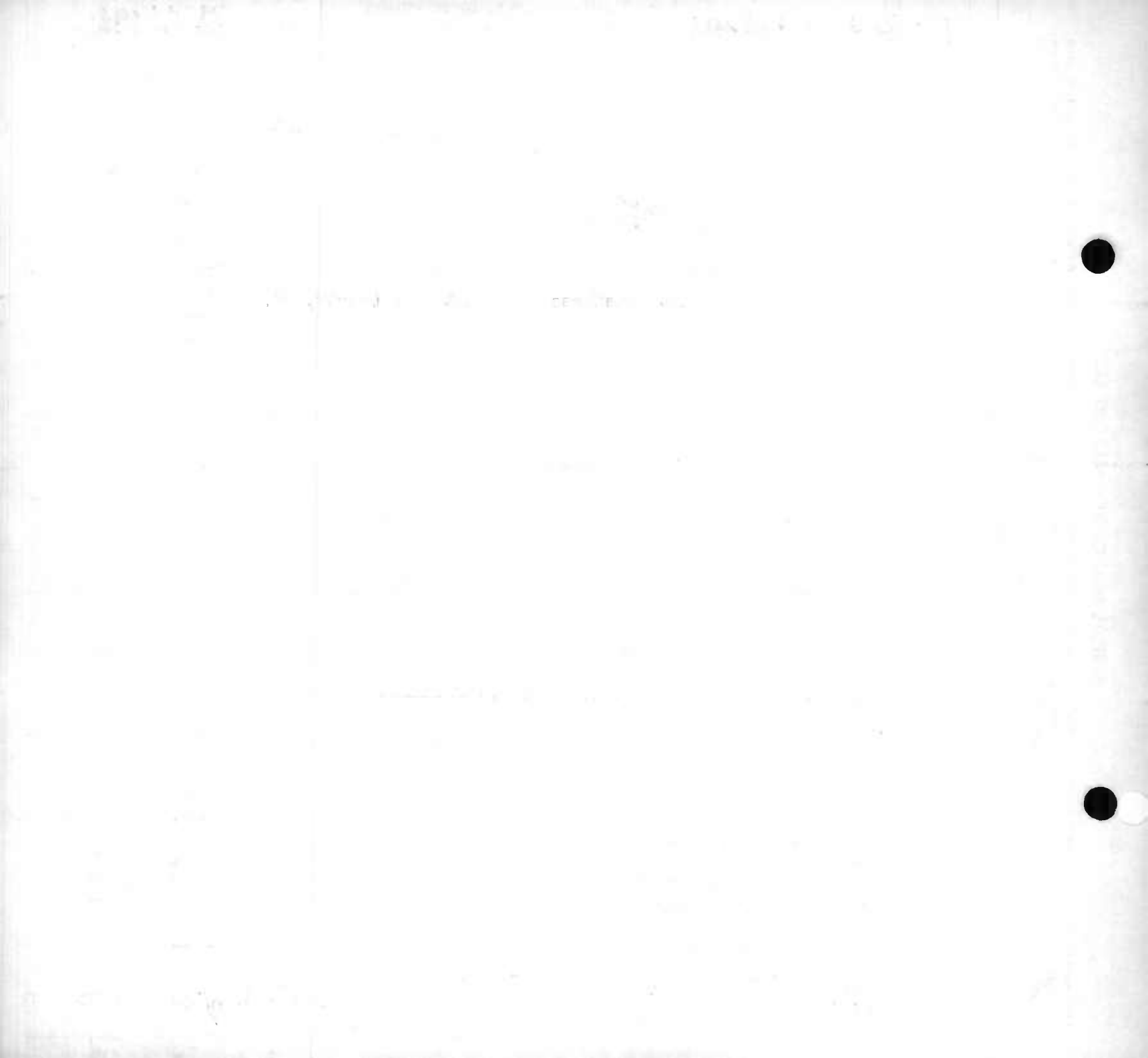
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 11493	
<div style="display: flex; justify-content: space-between;"> W-455 71 11493 CERTIFICATE OF DEATH </div>					
BIRTH NO. 1. NAME OF DECEASED (Type or Print) WILHELMINA MIANNE WALINIEMI		2. DATE AND HOUR OF DEATH DEC 11, 1971 12:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSPITAL 49		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1101 1101 ST. PAUL ST. APT. 1205			
5. SEX F		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —		8. DATE OF BIRTH 8/12/1884	
13. FATHER'S NAME JOHAN KALLIO		14. MOTHER'S MAIDEN NAME WILHELMINA SVENSON		9. AGE (In years last birthday) 87 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-07-3707 D		17. INFORMANT DAUGHTER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.4 I CEREBRAL VASCULAR ACCIDENT		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL VASCULAR ACCIDENT (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: 70 years (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 11/27 1971 to 12/11 1971, that (I) (we) last saw the deceased alive on 12/10 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 12/11/71		23C. PHYSICIAN'S NAME (Type) AGATON H. ESCALANTE M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/17/71		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR RACE, J. H. JR.		25C. FUNERAL DIRECTOR W. A. BROWN	
24D. LOCATION (City, town, or county) (State) BALTO. CO., MD		24E. ADDRESS 1101 ST. PAUL ST. APT. 1205			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

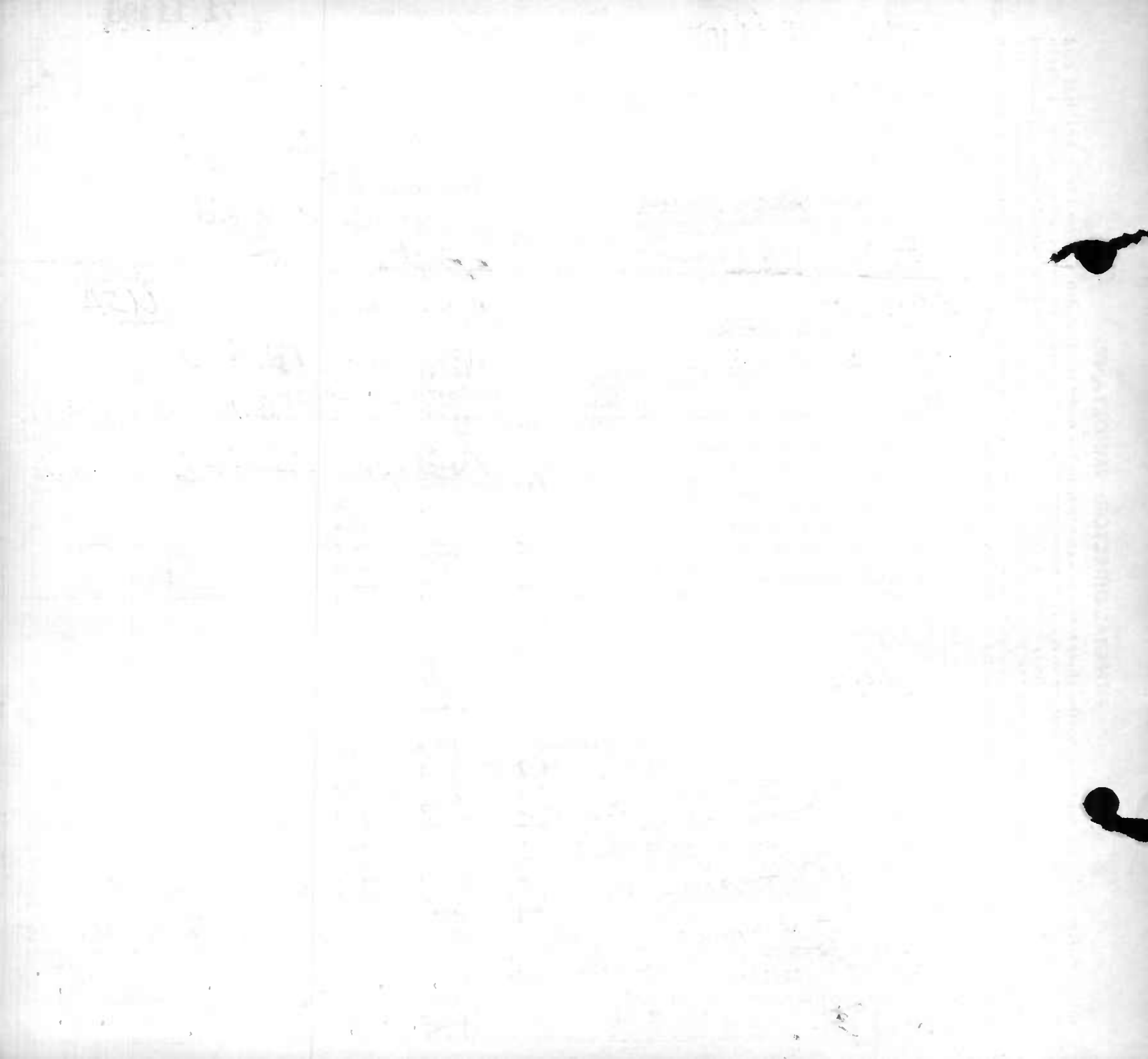
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
B-500 71 11494											
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) GEORGE H BEHM					2. DATE AND HOUR OF DEATH 12-8-71 7pm.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 33RD AND CALVERT STREETS					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland COUNTY Baltimore ZIP 5300						
5. SEX Male					6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 04-03-84		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Est Salesman					10B. KIND OF BUSINESS OR INDUSTRY Auto Business		11. BIRTHPLACE (State or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME George Behm					14. MOTHER'S MAIDEN NAME Margaret Friedrich						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 217-09-469		17. INFORMANT Saughier			ADDRESS 3721 Croydon Rd.	
18. 550X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE & Consequence of the death DUE TO, OR AS A CONSEQUENCE OF: Old age, Probable (Pneumonia) (B) Old age, Part of (Injured Heart) DUE TO, OR AS A CONSEQUENCE OF: (C) Old age (87 yrs) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Old age (87 yrs)											
19A. DATE OF OPERATION 12-6-71					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Injured Heart					20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX) 1 Month (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR				
22. I certify that (I) (this hospital) attended the deceased from 12-05-71 1971 to 12-8 1971 that (I) (we) last saw the deceased alive on 12-8 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE A. J. Khatrian MD					23B. DATE SIGNED 12-08-71			23C. PHYSICIAN'S NAME (Type) DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 12/11/71		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.		
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971					25B. NAME OF REGISTRAR 0000		25C. FUNERAL DIRECTOR Randallstown Md. ADDRESS 21133 LAURENCE BOULEVARD 8728 Liberty Rd.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 11495				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11495	
1. NAME OF DECEASED (Type or Print) <u>Deborah June Street</u>				2. DATE AND HOUR OF DEATH <u>12/8/71</u> <u>7:05 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1305 Willow Rd</u>			
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/22/56</u>	
9. AGE (in years last birthday) <u>15</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>David Street</u>			
14. MOTHER'S MAIDEN NAME <u>Maybelle Blevins</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT (Father) <u>Mr. David Street</u>			
18. <u>170.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>Osteogenic Sarcoma</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>6 months</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>None</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>May 19</u> 19 <u>71</u> to <u>Dec 8</u> 19 <u>71</u> that (1) <u>(we)</u> last saw the deceased alive on <u>Dec 8</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>(We)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>D M Haines MD</u>				23B. DATE SIGNED <u>12/8/71</u>		23C. PHYSICIAN'S NAME (Type) <u>D M Haines MD</u>	
23D. ADDRESS <u>601 N. Broadway Balto Md 05</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>12/12/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Monte Vista Burial Park, Inc.</u>		24D. LOCATION (City, town, or county) (State) <u>Washington Co. Johnson City, Tenn.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1971</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Balto. Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. C-340		71 11496		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 11496	
1. NAME OF DECEASED (Type or Print) Clarence E. Caddell Jr.				2. DATE AND HOUR OF DEATH Dec. 5, 1971 1:05 AM			
CERTIFICATE AMENDED FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital 12-17-71				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2101			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 815 N. Woodward St.			
5. SEX Male	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-15	9. AGE (in years last birthday) 56	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10B. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clarence E. Caddell Sr.				14. MOTHER'S MAIDEN NAME Helen ---			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes. WWII 1941		16. SOCIAL SECURITY NO. 215-10-0631		17. INFORMANT Clinical Record Dept.			
18. 43191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Endotracheal Hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Spontaneous Intracerebral Hemorrhage 7 days.			
19A. DATE OF OPERATION 11-29-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intracerebral Hemorrhage		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 29, 1971 to December 5, 1971 that (I) (we) last saw the deceased alive on December 5, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald R. Sissler M.D.				23B. DATE SIGNED Dec. 5, 1971		23C. PHYSICIAN'S NAME (Type) Donald R. Sissler M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 8, 1971		24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Pk.		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy.	

V.S. 153

12-17-71

M.H.

L-000

71 11497

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 11497

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALICE LEE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 11, 1971		Hour 4:00 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year December 11, 1971		Hour 4:00 A.M.
6. SEX Female		7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11/90/35		10. AGE (in years last birthday) 36	11. BIRTHPLACE (State or foreign country) BALTO. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME EARL AMOS		14. MOTHER'S MAIDEN NAME MARY Rootes
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		16. KIND OF BUSINESS OR INDUSTRY		17. SOCIAL SECURITY NO.
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		19. 18. INFORMANT LOUIS M. LEE		ADDRESS
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 988 X		CAUSE OF DEATH Subdural hematoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
22A. DATE OF OPERATION 2		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22C. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? ?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? ?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 11, 1971
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/71	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR Robert E. Gable, M.D.		25C. FUNERAL DIRECTOR Joseph G. Locks
				ADDRESS 1304 N. Calvert St.

2-1-1972 - Form - Completion of cause of death on a pending medical examiner death certificate
C. Springate, M.D.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 11498	
BIRTH NO. 71 11498		1. NAME OF DECEASED (Type or Print) GIBBS, McKinley		2. DATE AND HOUR OF DEATH 12/9/71 6:15 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 807			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1433 Broadway			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/05	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10B. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-4655		17. INFORMANT Mildred Gibbs		ADDRESS 1433 N. Broadway	
18. 431.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HYPERTENSIVE INTRACRANIAL BLEED				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BLEED		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION Autopsy		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Inter cerebral bleed		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/5 19 71 to 12/9 19 71 that (I) (we) last saw the deceased alive on 12/9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. A. Rizza M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/9/71	
23C. PHYSICIAN'S NAME (Type) R. A. RIZZA, M.D.		23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town or county) (State) D. C. County - Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		25B. NAME OF REGISTRAR Robert E. Saylor, M.D.		25C. FUNERAL DIRECTOR Joseph J. Bodo		ADDRESS 1304 N. Central Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 11499		71 11499	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FRED SINGLETON				2. DATE AND HOUR OF DEATH 12-8-71 2:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 925 N. CAROLINE ST				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 704			
5. SEX M		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/12/07	
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) S. C.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME ?			
14. MOTHER'S MAIDEN NAME ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT KATIE Singleton ADDRESS 925 N. CAROLINE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 412.2 + 195.0 A.S.H.C.V. Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1948			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				20. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Adeno-Carcinoma - abdominal Rt. hemiplegia			
21. (B) DUE TO, OR AS A CONSEQUENCE OF:				22. (C) DUE TO, OR AS A CONSEQUENCE OF:			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1968 1968			
25A. DATE OF OPERATION 0		25B. CONDITION FOR WHICH OPERATION WAS PERFORMED		26A. AUTOPSY? (Yes or No) no		26B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
27A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		27B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
28A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		28B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		28C. HOW DID INJURY OCCUR?			
29. I certify that (I) (this hospital) attended the deceased from 1948 to Dec 8 1971 , that (I) (we) last saw the deceased alive on Nov 8 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
30A. SIGNATURE RAYNER BROWNE, M.D.				30B. DATE SIGNED 12-11-71			
30C. PHYSICIAN'S NAME (Type) RAYNER BROWNE, M.D.				30D. ADDRESS 1800 EAST MADISON ST. BALTIMORE, MD. 21205			
31A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		31B. DATE 12/11/71		31C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		31D. LOCATION (City, town, or county) (State) BALTO. MD	
32A. DATE REC'D BY HEALTH DEPT. DEC 13 1971		32B. NAME OF REGISTRAR Robert E. Galt, R.D.O.		32C. FUNERAL DIRECTOR Joseph B. Lockhart		32D. ADDRESS 1304 N. Central Ave	

RECEIVED
JAN 10 1900
WASHINGTON, D. C.

10 10 1900

10 10 1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-352 71 11500		BALTIMORE CITY HEALTH DEPARTMENT		71 11500	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>HEADINGS Raymond</u>		2. DATE AND HOUR OF DEATH <u>12/8/71 @ 6:45 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>BALTO Md</u> B. COUNTY <u>BALTO, Co</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>49 North Charles Gen. Hosp.</u> <u>2724 N. CHARLES ST.</u>		C. CITY OR TOWN <u>BALTO Co</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>Rt. 14 Box 127</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-25</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROUTE SALESMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Jewell Co</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>ARTHUR S. HEADINGS</u>			
14. MOTHER'S MAIDEN NAME <u>LORNA KAUFMAN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>NAVY</u> <u>212-22-4637</u>			
16. SOCIAL SECURITY NO. <u>212-22-4637</u>		17. INFORMANT <u>Arthur Headings Rt. 14 Box 127 - 21220</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute pulmonary edema</u> <u>Cardio-respiratory arrest</u> <u>Acute pericarditis</u> <u>Pulmonary embolism</u> <u>Pulmonary CA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12-6-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pulmonary CA</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 24 1971</u> to <u>DECEMBER 8 1971</u> that (I) (we) last saw the deceased alive on <u>DEC. 8 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Arturo P. Pangilinan M.D.</u>				23B. DATE SIGNED <u>12-8-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ARTURO P. PANGILINAN M.D.</u>		23D. ADDRESS <u>NORTH CHARLES HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-11-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Edenwood Cem.</u>	
24D. LOCATION <u>BALTO. MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1971</u>			
25B. NAME OF REGISTRAR <u>John E. Kelly, Md.</u>		25C. FUNERAL DIRECTOR <u>B. Dabrowski 2818 E. BALTO. ST.</u>			

